

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

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

- Oklahoma Department of Human Services (DHS) has been updated to Oklahoma Human Services (OHS) throughout the document.
- Appendix A, question A-4 regarding local or regional non-state entities performing waiver operational and administrative functions is being changed to not applicable and all references to LTCA of Enid are being removed from the document. OHS no longer contracts with LTCA of Enid and responsibilities are now completed by OHS.
- Appendix B, updated to reflect medical eligibility assessments completed through an electronic format (phone, video conference, etc.). The OHS nurse determines level of care based upon the outcome of the assessment unless the applicant is determined to be medically ineligible. In this case, a face-to-face visit is scheduled to either validate the electronic assessment or provide additional documentation to support the applicant meeting medical level of care. Applicants shall not be medically denied access to the waiver solely based on an assessment completed through an electronic format.
- Appendix C, C-2-d services and supports provided by a legally responsible individual has been updated to reflect policy updates to Oklahoma Administrative Code 317:30-5-761.
- Appendix D, D-1-c Case Management training section was updated to remove a self- evaluation tool would be used to evaluate the Case Managers Interdisciplinary Team meeting (IDT) facilitation performance. The tool is not required.
- Appendix E, updated to allow the contracted Financial Management Services provider (FMS) for the self-directed service option to also provide the Electronic Visit Verification system (EVV), to comply with the 21st Century Cures Act.
- Appendix E, section Grievance/Complaint System, updated to clarify Escalated Issues processes and revise timelines.
- Appendix F, updated with Fair Hearing notification language used by OHS.
- Appendix G, policies referenced updated to current Oklahoma Administrative Code and how to notify Adult Protective Services of Abuse Neglect and Exploitation (a/n/e).
- Appendix G, in instances of substantiated abuse, neglect, or exploitation by paid caregivers a referral is sent to the OHS Adult Protective Services for screening then sent to Office of Client Advocacy (OCA) for further investigation.
- Appendix I, the rates for waiver services were updated to match OHCA rate methodologies.
- Appendix J, updated to reflect the State's financial estimates for waiver years 1-5.
- Other changes include general clarification, alignment with state statute and clean-up throughout the waiver document.

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

1. Request Information (1 of 3)

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

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

ADvantage

C. Type of Request: renewal

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

3 years 5 years

Original Base Waiver Number: OK.0256

Waiver Number: OK.0256.R06.00

Draft ID: OK.012.06.00

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

Regular Waiver

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

07/01/21

Approved Effective Date: 07/01/21**PRA Disclosure Statement**

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

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

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

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

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

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

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

§1915(b)(2) (central broker)

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Oklahoma's ADvantage Waiver Program

Under the Medicaid Home and Community-Based Waiver ADvantage Program, Oklahoma Human Services, Division of Aging Services, offers the following services to eligible adults as an alternative to care in a nursing facility:

Case Management Services Personal Care

Respite Care

Adult Day Health Care with Personal Care and Therapy Enhancements Environmental Modifications

Specialized Medical Equipment and Supplies

Advanced Supportive/Restorative Assistance

Nursing Prescription Drugs

Home-Delivered Meals

Therapy Services: Physical and Occupational Hospice Care

Personal Emergency Response System (PERS) Institution Transition Services

Consumer-Directed Personal Assistance Services and Supports (CD-PASS) Assisted Living Services

Skilled Nursing

The goal of this program is to provide services which allow Medicaid eligible persons who need nursing facility level of care to remain at home or in the residential setting of their choosing while receiving the necessary care. The ADvantage Program is a home and community-based alternative to placement in a nursing facility to receive Medicaid-funded assistance for care. The objective of the program is to offer to every individual who requests, is financially eligible and meets nursing facility level of care, the ability to choose between nursing facility and home and community based services, with free choice of available providers for the services included in the individual's plan of care.

The program uses agency and individual self-direction methods of service delivery. The ADvantage waiver incorporates self-direction opportunities as a service delivery mechanism statewide. The program is cost effective, in that Medicaid expenditures for services under the ADvantage Waiver must be less than the Medicaid-funded institutional services would have been had the individuals been served in a nursing facility.

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

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

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

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

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

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

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

4. Waiver(s) Requested

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

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

Not Applicable

No

Yes

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

No

Yes

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

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

Limited Implementation of Participant-Direction. A waiver of statewide requirements 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

The following processes and forums have provided opportunity for public input to the waiver amendment process:

In order to fulfill the non-electronic requirements for public comment, the State posted written notices in all county offices to ensure meaningful opportunities for input for individuals served or eligible to be served in the waiver. The public notice contained a summary of the changes and instruction where individuals could submit comments and request a full copy of the waiver. This comment period was open from February 1, 2021 – March 2, 2021; there were no public comments received during the input process; therefore, no comments were adopted.

On January 25, 2021 OHCA submitted a SoonerCare Tribal Notification letter via email to tribal partners to give notice of the proposed waiver renewal. The item request a expedited 14-day tribal consultation comment period from January 25, 2021 through February 24, 2021. Comments about the proposed policy change, was directed to the online comment system found on the Policy Change Blog and/or the Native American Consultation Page. There were no public comments received during the input process; therefore, no comments were adopted.

The ADvantage waiver renewal was placed on the OHCA website for public comment from February 1, 2021- March 2, 2021; there was one public comment received during the input process, it's listed below along with the State's response.

The waiver was posted at http://okhca.org/providers.aspx?id=12395#Home_and_Community_Based_Services_Waivers.

Comment: The requirement in this waiver for Home-Delivered Meals Service Providers to meet “Title III Program Home-Delivered Meal Provider Standards” creates an unreasonable restriction on provider competition and Member choice within the ADvantage Program. To certify that providers meet the Title III Home Delivered Meals Standards, the ADvantage Program has a requirement that providers hold a current Title III Nutrition contract. This requirement limits the number of providers and the types of providers who may provide ADvantage Home Delivered Meals. This limitation of the number of providers and types of providers negatively impacts Member choice and stifles fair competition between qualified Home Delivered Meals providers. The numbers of in-state providers that are eligible to become ADvantage Providers are limited by the Oklahoma Title III Nutrition contracting process of only awarding a single in-state nutrition provider in each county. This process creates barriers for in-state providers that do not choose to contract with Title III, but are nonetheless committed to providing high quality Home Delivered Meals in Oklahoma. This contracting practice both limits Member choice and reduces competition at the same time. The types of providers are unreasonably limited to those that provide Congregate Meals and Home Delivered Meals, when the only service on the ADvantage Waiver is Home Delivered Meals. Providers that only provide Home Delivered Meals are not eligible for a Title III Nutrition contract in Oklahoma. Oklahoma Title III Nutrition contracts require the provision of both Congregate Meals and Home Delivered Meals; thus, only those Home Delivered Meal Providers with Congregate Meals sites are potentially eligible to provide ADvantage Home Delivered Meals. Congregate Meals is not an ADvantage service. This creates an arbitrary disqualification that further restricts competition of Home Delivered Meal providers and limits Member choice. It is requested that the “Title III Program Home-Delivered Meal Provider Standards” requirement be removed and replaced with quality assurance standards that maximize Member Choice and increases provider competition to promote greater quality services.

State Response: The ADvantage waiver program specifically utilizes Title III meal providers to assure that meals provided to waiver members meet the same nutritional standards set by the Older Americans Act. Meals are monitored by a registered dietician to comply with the Dietary Guidelines for Americans and to provide a minimum of one-third of the daily recommended dietary reference intakes (DRIs) established by the Food and Nutrition Board of the Institute of Medicine (IOM). ADvantage does not have the ability to independently monitor meal providers and utilizes the expertise of the Title III programs for this oversight.

To address the issue of limited choice, ADvantage accepts out of state providers having Title III contracts in their own states where meal planning and menu implementation is done. To date, Oklahoma has two statewide providers to promote member choice and ensure provider choice in any community without a local Title III presence.

For the reasons stated above, ADvantage will continue to utilize Title III providers for the home delivered meals service.

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

Medicaid Agency.

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

7. Contact Person(s)

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

Last Name:

Ward

First Name:

David

Title:

QA & Community Living Services Manager

Agency:

Oklahoma Health Care Authority

Address:

4345 N. Lincoln Boulevard

Address 2:

City:

Oklahoma City

State:

Oklahoma

Zip:

73105

Phone:

(405) 522-7776

Ext:

TTY

Fax:

(405) 530-7722

E-mail:

David.Ward@okhca.org

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

Last Name:

Kelley

First Name:

Kathleen

Title:

Aging Services Deputy Director

Agency:

Address:	Oklahoma Human Services		
Address 2:	PO Box 35900		
City:	Tulsa		
State:	Oklahoma		
Zip:	74153		
Phone:	(918) 493-0604	Ext:	TTY
Fax:	(405) 230-8028		
E-mail:	Kathleen.Kelley@okdhs.org		

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Melody Anthony
	State Medicaid Director or Designee
Submission Date:	Jun 25, 2021

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

Last Name:	Per OHCA
First Name:	Per OHCA
Title:	Per OHCA
Agency:	Oklahoma Health Care Authority
Address:	Per OHCA

Address 2:

Per OHCA

City:

Oklahoma City

State:

Oklahoma

Zip:

73105

Phone:

(405) 522-7722

Ext:

TTY

Fax:

(405) 530-7722

E-mail:

Attachments

David.Ward@okhca.org

Attachment #1: Transition Plan

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

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

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

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

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

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

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

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's

05/12/2022

HCBS settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

The waiver is operated by the state Medicaid agency.

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

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Oklahoma Human Services (OHS)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid

Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

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

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

The Interagency Agreement is reviewed and updated at least annually.

The OHCA (Medicaid agency) utilizes several processes to assess the performance of OHS (Operating agency). The frequency of assessment of function depends upon the individual process but is usually on a monthly or quarterly basis. Described below are the different processes used to assess Operating agency performance.

Enrollment – The Medicaid Agency monitors the OHS processes and performance in Medicaid applicant enrollment in compliance with the Interagency Agreement. The OHCA monitors the enrollment process utilizing two committees which monitor enrollment activities and any problems related to enrollment. The Steering Committee meets quarterly and includes senior level staff from the OHCA and OHS. This committee makes decisions related to eligibility and programs issues and provides direction for the Quality Management Strategies Council (QMSC). The QMSC, which includes representatives from OHS and OHCA, provides technical assistance and investigates for the Steering Committee and works on eligibility problems which do not require attention from senior level staff. The QMSC develops and regularly reviews reports which reflect the timeliness and accuracy of the enrollment process and the efficiency of data exchanges between OHCA and OHS. The Medicaid Agency monitors the Operating agency performance on all other assigned waiver operational and administrative functions in accordance with waiver requirements through review of periodic (monthly or quarterly) reports and participation in quarterly meetings the Quality Management Strategies Council (QMSC). The OHCA Waiver Administration Director responsible for waiver administration receives a copy of all waiver management reports and takes a lead role in the Quality Management Strategies Council (QMSC).

The performance is monitored by the OHCA Waiver Administration Director based on performance standards. OHS (the Operating agency) is responsible for providing upon request, at a minimum, quarterly reports of activities furnished in support of waiver members. These reports are analyzed by the Senior Program Manager. On a quarterly basis, the Waiver Administration Director assesses performance. Although contractor performance is monitored on an ongoing basis by the Waiver Administration Director, formal performance assessment of the Operating Agency occurs at least once each year as part of the annual readiness review and operational compliance review of the Interagency Agreement.

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

- Collect and process timesheets of support workers
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Maintain a separate account for each participant’s participant-directed budget
- Track and report participant funds, disbursements and the balance of participant funds
- Process and pay invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Keep on file the worker Medicaid provider agreements
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency, and
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget

A private entity has been contracted through an RFP process to provide an electronic visit verification (EVV) system to be used by ADvantage service providers of Home Care and Case Management services statewide. The system is a time and attendance verification and tracking system supported through specialized telephony and GPS based software. The system allows real-time tracking of service delivery with alerts for missed or late visits. The system provides numerous management reports for providers and for the state to review service utilization.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Oklahoma Human Services (OHS)

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 OHS Contract Manager reviews monthly reports that track and summarize the performance of the FMS vendor in meeting contract performance standards for CD-PASS member customer support. In addition, OHS and OHCA staff participate in monthly teleconference calls with FMS vendor staff to review these management reports and review issues related to contracted responsibilities. OHS staff reviews on an ongoing basis individual and aggregated reports that track CD-PASS member budget disbursements. OHS and OHCA regularly review FMS vendor performance of contracted responsibilities during quarterly QMSC meetings.

OHS and OHCA staff participate in monthly teleconference calls with EVV vendor staff to review issues related to contracted responsibilities in implementing the EVV system, including issues raised by providers in using the system. OHS staff review on an ongoing basis EVV reports aggregated by provider that track service delivery including missed or late visits, claims payments, use of unauthorized phone for tracking service delivery and voice authentication failures. OHS and OHCA regularly review EVV vendor performance of contracted responsibilities during quarterly QMSC meetings.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment			
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			

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Establishment of a statewide rate methodology			
Rules, policies, procedures and information development governing the waiver program			
Quality assurance and quality improvement activities			

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

Number and percentage of service plans for new members having authorization reviews completed by OHS in the timeframe specified in agency policy. Numerator: Number of service plans for new members having authorization reviews completed by OHS in the timeframe specified in policy. Denominator: Number of service plan reviews completed for new members.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data-Entry Retrieval System (ELDERS) and Waiver Information Management Systems (WMIS)

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percentage of member service plans that do not exceed approved waiver expenditure levels according to OHS and Medicaid Agency interagency agreement.

Numerator: Number of member service plans that do not exceed approved waiver expenditure levels. Denominator: Total number of member service plans.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ADvantage Waiver Management Information System (WMIS)

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMS Performance monitoring

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

Specify: <input type="text" value="FMS Provider"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of CD-PASS members whose utilization of CD-PASS services does not exceed approved service plan limits. Numerator: Number of CD-PASS members whose utilization of CD-PASS services does not exceed approved service plan limits. Denominator: Total number of CD-PASS members.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMS provider reports

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1042 678 1246 759" type="text"/>
Other Specify: <input data-bbox="331 902 587 947" type="text" value="FMS Provider"/>	Annually	Stratified Describe Group: <input data-bbox="1042 902 1246 983" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1042 1126 1246 1207" type="text"/>
	Other Specify: <input data-bbox="659 1350 917 1431" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="323 1977 748 2058" type="text"/>	Annually

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

Performance Measure:

Number and percentage of initial LOC determinations made by OHS within the timeframe specified in Medicaid agency policy. Numerator: Number of initial LOC determinations made within the timeframe specified in policy Denominator: Total number of initial LOC determinations

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data-Entry and Retrieval System (ELDERS)

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 80%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 80%; height: 20px;" type="text"/>

Performance Measure:

Number and percentage of members enrolled by OHS in the waiver according to policy as outlined in the agreement with the Medicaid agency. Numerator: Number of members enrolled in the waiver by OHS according to policy and interagency agreement. Denominator: Total number of members enrolled in waiver.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS, ELDERS and WMIS Information Management Systems

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

		Interval = <input type="text" value="95%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of Assisted Living (AL) and Adult Day Health (ADH) facilities that meet HCB settings requirements. Numerator: Number of AL and ADH facilities that meet

HCB requirements. Denominator: Total Number of ADH and AL facilities.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

ADvantage Waiver Management Information System (WMIS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percent of days EVV system operates and supports the required business applications for performance and availability for use in accordance with state agreement.

Numerator: Number days that EVV system is operational and available for use by providers. **Denominator:** Total Number of days in reporting period.

Data Source (Select one):

Other

If 'Other' is selected, specify:

EVV Provider Performance monitoring

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

Number and percentage of providers certified as qualified by OHS prior to enrollment in accordance with the OHS interagency agreement with the Medicaid Agency. Numerator: Number of providers certified as qualified by OHS prior to enrollment. Denominator: Number of providers enrolled

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="325 546 751 629" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="820 831 1246 913" type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OHS dedicated waiver staff are responsible for program monitoring and oversight and address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OHS Point of Contact to resolve any problems in a timely manner.

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

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

Member Enrollment/LOC/Waiver Policies

Medicaid Agency staff monitor that ADvantage level of care (LOC) and enrollments have been completed in accordance with required time-frames and other policy requirements. If any instances are found in which LOC was not performed within policy timeframes or enrollment was not completed according to policy requirements, OHS is contacted directly for resolution and, if deemed necessary, OHS will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development.

Member Service Plans

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

Qualified Providers

If any instances are found in which providers have been certified prior to enrollment, OHS is contacted directly for resolution and, if deemed necessary, OHS will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development.

Remediation of non-State entity contracted functions:

Financial Management Services Fiscal Agent

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

Electronic Visit Verification Contractor

If any instances are found in which the EVV provider has not adequately supported the EVV system to be available for use in accordance with the state agreement, the EVV provider is contacted directly for resolution

and, if deemed necessary, the EVV provider will be required to submit, within five working days of request, a corrective action plan to the OHS Contract Manager who will share the plan with the Director of Waiver Administration and Development. In addition, liquidated damages may be assessed against the EVV provider for certain performance measure failures if in violation of contract requirements.

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Aged	65		
		Disabled (Physical)	21	64	
		Disabled (Other)	21	64	
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

Disabled (Physical) and Disabled (Other) excludes individuals who have an Intellectual Disability or Developmental Disability with cognitive impairment.

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

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Once Members, with disabilities reach the age of 65, they are transitioned to the categorically eligible Aged subgroup. These members continue receiving ADvantage services as long as they continue to meet financial and medical eligibility criteria.

Appendix B: Participant Access and Eligibility

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

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

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to

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

The limit specified by the state is (select one)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. Complete Items B-2-b and B-2-c.

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed 100% of the institutional average Medicaid cost for that individual.

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

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

The OHS nurse reviews with and provides all ADvantage applicants a freedom of choice form that outlines their right to a fair hearing OHS. The member is informed by OHS staff and by the Case Manager of their right to receive a fair hearing regarding any decision with a potentially adverse impact, including choice of service setting (institution or waiver services), choice of provider or of service, or a denial, reduction, suspension or termination of services.

In accordance with 317:2-1-5 Hearing procedures, 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 the right to appeal. Copies of the notices are maintained in the OHS Information Management Services (IMS) system. 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 through a free legal assistance program. The written notice includes information about how to file an appeal and the time frame in which an appeal must be filed. The Request for a Fair Hearing explains that, if a fair hearing is requested, the member will continue to receive services until a decision is made on the appeal.

The member 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, OK 73154-0497
OHCA Fax Number is (405) 530-3455
OHCA Docket Clerk Telephone Number is (405)522-7217

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

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

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

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

If there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that would exceed the cost limit in order to assure the participant's health and welfare, an increase in frequency of waiver service or number of waiver services may be approved for a temporary period, not to exceed 60 days, during which access to appropriate care is arranged. To the extent that waiver services can be utilized within the 60-day period and the member's service plan not exceed the cost limit, waiver services will be utilized. If the cost of continuing a service plan cannot be accomplished within the waiver cost limits, the member will be disenrolled from the waiver on a date prior to the date on which estimated service costs under the waiver would exceed the cost limit. If the individual has been disenrolled from the waiver and still requires services to meet needs within the service transition or appeal rights period, a service plan with required services will be authorized as "State Only" and providers of services will be reimbursement with State funds only. State-funded only plans must be reviewed and receive approval from MSU leadership.

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

Other safeguard(s)

Specify:

The member is informed by the OHS 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 maintained in the OHS IMS system. The member is informed that a request for a fair hearing regarding eligibility must be submitted in writing to the Legal Division of OHCA, P.O. Drawer 18497, Oklahoma City, OK 73154-0497. The applicant is also advised of the right to legal counsel at the hearing by either a private attorney or free legal help. The written notice includes information about how to access free legal help, where and how to file an appeal, and the time frame in which an appeal must be filed. The Request for a Fair Hearing explains that the member will continue to receive services if a hearing is requested until after a decision is made.

The member also receives written information about the right to request a Fair Hearing and the steps in the process regarding appeals with respect to services. The member is to use the LD-1 form to file a request. The LD-1 form is to be mailed to:

Oklahoma Health Care Authority
Grievance Docket Clerk- Legal Division
P.O. Drawer 18497
Oklahoma City, Oklahoma 73154-0497 OHCA Fax Number is (405) 530-3455
OHCA Docket Clerk Telephone Number is (405) 522-7217

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (1 of 4)**

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	24375
Year 2	24375
Year 3	24375
Year 4	24375
Year 5	24375

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

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

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

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

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

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

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

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

Entry to the waiver is offered to individuals based on the date of their application for the waiver.

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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

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

Specify:

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

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

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR §435.217

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

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

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

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

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (3 of 7)**

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

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

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

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (4 of 7)**

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

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

The following formula is used to determine the needs allowance:

Specify formula:

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

Other

Specify:

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

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

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

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

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

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

The state does not establish reasonable limits.

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

The provision of waiver services at least monthly

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

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

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

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

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

Registered Nurse licensed in the State of Oklahoma or a Registered Nurse license recognized by the State of Oklahoma via the Enhanced Nurse Licensure Compact (eNLC). The nurse is an employee of OHS and has successfully completed Uniform Comprehensive Assessment Tool training.

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

According to OAC 317:35-17-2, Level of care medical eligibility determination, the OHS Area Nurse or Nurse Designee determines medical eligibility for ADvantage program services based on the OHS Uniform Comprehensive Assessment Tool (UCAT) III assessment and the determination that the member has unmet care needs that require ADvantage or NF services to assure member health and safety.

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

(A) The UCAT documents the need for assistance to sustain health and safety as demonstrated by:

- (i) either the ADLs or MSQ score is in the high risk range; or
- (ii) any combination of two or more of the following:

(I) ADLs score is at the high end of moderate risk range; or, (II) MSQ score is at the high end of moderate risk range; or, (III) IADLs score is in the high risk range; or, (IV) Nutrition score is in the high risk range; or, (V) Health Assessment is in the moderate risk range, and, in addition,

(B) The UCAT documents the absence of support or adequate environment to meet the needs to sustain health and safety as demonstrated by:

- (i) Member Support is moderate risk; or,
- (ii) Environment is high risk; or,
- (iii) Environment is moderate risk and Social Resources is in the high risk range; or, regardless of whether criteria under (A) of need and (B) of absence of support are met;

(C) Expanded criteria: The UCAT documents that:

- (i) the member has a clinically documented progressive degenerative disease process that will produce health deterioration to an extent that the person will meet OAC 317:35-17-2(2)(A) criteria if untreated; and
- (ii) the member previously has required Hospital or NF level of care services for treatment related to the condition; and
- (iii) a medically prescribed treatment regimen exists that will significantly arrest or delay the disease process; and
- (iv) only by means of ADvantage Program eligibility will the individual have access to the required treatment regimen to arrest or delay the disease process.

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

For initial level of care (LOC), the OHS nurse assesses the applicant through an electronic format (phone, video conference, etc.) using the Uniform Comprehensive Assessment Tool (UCAT) unless there are limiting factors which necessitate a face-to-face assessment. The OHS nurse determines nursing facility level of care eligibility based upon the outcome of the assessment unless the applicant is determined to not meet nursing facility level of care. In this case, a face-to-face visit is scheduled to either validate the initial electronic assessment or provide additional documentation to support the applicant meeting nursing facility level of care. Applicants shall not be denied access to the waiver solely based on an assessment completed through an electronic format.

For LOC reassessment, the member's Case Manager (CM), as part of the annual service plan review and development process, assesses the member in their home or other appropriate setting using the UCAT. The UCAT is then reviewed by an OHS nurse for the level of care re-evaluation determination. In the event the UCAT completed by the Case Manager does not provide sufficient documentation to support the member's continued eligibility in meeting nursing facility level of care for waiver services, the member is referred to the local OHS nurse. The OHS nurse then re-assesses the applicant using the UCAT through an electronic format (phone, video conference, etc.) unless there are limiting factors which necessitate a face-to-face assessment. The OHS nurse determines level of care based upon the outcome of the assessment unless the applicant is determined to not meet nursing facility level of care. In this case, a face-to-face visit is scheduled to either validate the electronic assessment or provide additional documentation to support the applicant meeting nursing facility level of care. Applicants shall not be denied access to the waiver solely based on an assessment completed through an electronic format.

Signature requirements for applicants' agreement of choice of institutional care versus home and community-based services and choice of case management and home care service providers may be obtained via secure electronic methods, postal mail, or wet signature during a home visit.

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

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

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

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

The qualifications are different.

Specify the qualifications:

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

Member periodic reassessment is a component part of case management and is required annually as part of the annual service plan reevaluation process. Assessment occurs prior to the end of the service plan year, which coincides with the medical level of care (LOC) eligibility end date. The OHS Medicaid Services Unit (MSU) monitors timely submission of UCAT documentation from Case Managers for the annual re-evaluation of service plans and for nursing facility level of care recertification.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3

years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Oklahoma Human Services (OHS) ADvantage waiver management information system (WMIS).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and percentage of applicants requesting services who receive a LOC evaluation. Numerator: Number of applicants requesting services who receive a LOC evaluation. Denominator: Total number of applicants requesting services.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data-Entry Retrieval System (ELDERS)

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data-Entry Retrieval System (ELDERS)

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Percentage of member initial LOC determinations completed that used the Uniform Comprehensive Assessment Tool (UCAT). Numerator: Number of members with initial LOC determinations completed using the UCAT. Denominator: Total number

of members receiving LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Electronic Data-Entry Retrieval System (ELDERS) and Waiver Management Information System (WMIS)

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 958 1264 1039" type="text"/>
Other Specify: <input data-bbox="408 1182 647 1263" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1182 1264 1263" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1406 1264 1487" type="text"/>
	Other Specify: <input data-bbox="718 1630 954 1711" type="text"/>	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OHS dedicated waiver staff are responsible for program monitoring and oversight and will address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OHS Point of Contact to resolve any problems in a timely manner.

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

The options for remediation are listed below. Remediation for Level of Care Assurances:

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

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

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

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

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

i. Description of procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver:

During the assessment visit, the OHS nurse informs the member and family of agencies certified to deliver ADvantage case management and in-home care services in the member's local area to obtain their informed choices of primary and secondary service providers. During this discussion, the OHS nurse educates the member and family on CMS' conflict free case management requirements in order to support informed decision making.

If the member and/or family decline to make a provider choice, the nurse documents that decision on the member choice form. The OHS Medicaid Services Unit (MSU) uses a rotating system to select a case management agency and a home care agency for the members with no preference of providers from a list of all local certified case management and in-home care agencies.

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

ii. Description of the State's procedures for allowing individuals to choose either institutional or home and community-based services:

As part of the assessment and eligibility process, members (and/or their legal guardians or representatives) are informed, both verbally and in writing, of the care alternatives of (1) institutional and (2) home and community based services. The member (or legal guardian, if applicable) indicates his/her choice of long-term care setting for service delivery.

Signature requirements for applicants' agreement of choice of institutional care versus home and community-based services and choice of case management and home care service providers may be obtained via a secure electronic method, postal mail, or wet signature during a home visit.

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

Copies of member Freedom of Choice documentation are maintained in member files in OHS internal electronic information systems.

Appendix B: Participant Access and Eligibility

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

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

Whenever waiver applicants have limited proficiency in English, a telephone interpretive service is accessed to support the communication process. The state contracts with interpreters to provide translation services when needed. The state also contracts for the provision of interpreter services for the hearing impaired.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Assistance with eating, mobility and toileting are personal care services that are integral to the Adult Day Health Care service and are covered by the Adult Day Health Care basic reimbursement rate.

Personal care service enhancement in Adult Day Health Care is assistance in bathing, hair care and/or laundry assistance and is not a usual and customary adult day health care service. Enhanced personal care in adult day health care for assistance with bathing, hair washing or laundry service will be authorized when an ADvantage waiver member who uses Adult Day Health Care requires assistance in these areas to maintain health and safety.

Physical and occupational therapies are defined under skilled therapy services.

Speech and Language Therapy Services Service Definition:

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

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

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

The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a member toward speech-language communication goals in the plan of treatment would be a covered speech-language pathology service.

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

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

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

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

Speech and Language Therapy Service Components:

1. Evaluation
2. Voice Disorders Treatments
3. Speech Articulation Disorders Treatments

- 4. Dysphagia Treatments
- 5. Language Disorders Treatments
- 6. Aural Rehabilitation
- 7. Maintenance Therapy Program

Therapy services, when indicated in the recipient's plan of care, will be furnished as an enhancement to basic Adult Day Health Care services. As a cost-containment measure, enhanced personal care and/or therapies in Adult Day Health Care are reimbursable on a per episode basis as an Enhancement to basic Adult Day Health Care.

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Adult Day Health services are authorized in 15 minute units, with no more than 32 units (8 hours) authorized per day. Units of Adult Day Health service enhancement for Personal Care and/or for Physical, Occupational, or Speech Therapy are authorized and billed in addition to standard Adult Day Health service units. Adult Day Health Personal Care Enhancement is a maximum one unit per day for either bathing, hair care, or laundry service.

If a member requires assistance with ADL/IADL needs beyond what may be provided through Adult Day Health, the member may also receive personal care services to meet their needs in their home either before or after the period of service in Adult Day Health for that day, if necessary. If personal care services are needed in the home before or after the period of time when the person is being served in an Adult Day Health Center, the member's Case Manager incorporates these services into the member's service plan.

MSU will review service plans to ensure that duplication of services does not occur.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Care Center

Provider Qualifications

License (specify):

Adult Day Care Center Title 63 O.S., Sec. 1-870, et seq.

Certificate (specify):

None

Other Standard (specify):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- 2) Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrollment.

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Health

Provider Category:

Individual

Provider Type:

Therapist

Provider Qualifications

License (specify):

- Physical Therapist – 59 O.S. Sec. 888.1, et seq.;
- Occupational Therapist – 59 O.S. Sec. 887.1, et seq.;

Certificate (specify):

None

Other Standard (specify):

Employed by the ADvantage Adult Day Health Center

Verification of Provider Qualifications

Entity Responsible for Verification:

Adult Day Care provider

Frequency of Verification:

Re-verified as necessary

Appendix C: Participant Services

C-1/C-3: 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:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Case Management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services that may benefit the member in maintaining health and safety.

Case managers initiate and oversee necessary assessments and reassessments for service plan development. With member guidance, case managers document the member's comprehensive plan of care, listing services which are necessary to prevent institutionalization of the member as determined through the interdisciplinary team planning process. Case managers are responsible for ongoing monitoring of the provision and quality of services included in the member's plan of care. Case managers initiate the addition of necessary services or deletion of unnecessary services, as directed by the member, according to the member's condition and their available supports.

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. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Agency

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Agency

Provider Qualifications

License (*specify*):

None

Certificate (*specify*):

None

Other Standard (*specify*):

1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
 2) Medicaid Provider Contract
 3) Minimum qualifications for Case Manager are:
 a. RN with one year paid professional experience; or
 b. LPN with one year paid professional experience; or
 c. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained before or after receipt of degree; and
 4) A minimum of one week of orientation to the agency’s policies and procedures to include shadowing a certified Case Manager in the field (documentation of orientation to be submitted to the MSU before the ADvantage CM Training date).

*Paid professional experience may include, but is not limited to: Certified Nursing Assistant, Certified Medical Assistant, Certified Home Health Aid or Personal Care Assistant experience.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Assistance with eating, bathing, dressing, and personal hygiene activities of daily living are personal care services. 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 assistance with instrumental activities of daily living, such as housekeeping chores (bed-making, dusting, vacuuming), shopping and errands, or other tasks or errands which are incidental to the care furnished or 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 meet nursing facility level of care. The scope, nature and provider type include heightened quality planning and monitoring activities by agencies delivering ADvantage waiver personal care. This level of quality planning and monitoring is not required for State Plan Personal Care services. State Plan Personal Care is afforded to individuals with lower level of care needs than members receiving waiver services.

Supervision of personal care providers will be furnished by a registered nurse or a licensed practical nurse with a license in good standing and according to the guidance of the Oklahoma Board of Nursing. Frequency or intensity of supervision is a minimum of every 6 months or more often if required by the member's person-centered service plan.

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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	Personal Care

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Care

Provider Qualifications

License (*specify*):

Home Care Agency
63 O.S., Sec. 1-1961, et seq.

Certificate (*specify*):

None

Other Standard (*specify*):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- 2) Medicaid Provider Contract
- 3) The PCA is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1 - 1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Health Nurse Aide Registry, and name does not appear on the OKOHS Community Services Workers Registry.
- 4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, and has verifiable identification.

Training Requirements:

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

Nurse Supervision Requirements:

- 1) Nurse supervision of Personal Care services is a state requirement of the Medicaid Program. Nursing services primarily provide nurse supervision to the personal care assistant or the advanced supportive/restorative assistance aide and assess the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A licensed nurse shall make a supervisory visit to the client's residence at least once every six (6) months. The frequency of supervisory visits shall be increased if the acuity of the client's situation requires more frequent visits.
- 2) Per OAC 310:662-5-2, the plan of care shall be revised as necessary, but it shall be reviewed and updated by the registered nurse at least every six (6) months.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Respite care will be provided in the following locations:

- 1) In-Home and Extended In-Home Respite in the individual's home or place of residence;
- 2) Nursing Facility Respite in a Medicaid certified Nursing Facility.

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

In-home Respite required for periods of time of seven or less hours in a day is authorized in 15-minute unit increments up to a maximum of 28 units per day.

Extended In-home Respite, defined as respite required for periods of time of more than seven (7) hours in a day, is authorized at a per diem rate.

Nursing Facility Respite is also authorized at a per diem rate.

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	Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care

Provider Qualifications

License (specify):

Home Care Agency
63 O.S., Sec. 1-1961, et seq.

Certificate (specify):

None

Other Standard (specify):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- 2) Medicaid Provider Contract
- 3) Respite provider is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OHS Community Services Workers Registry.
- 4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Facility

Provider Qualifications

License (specify):

Nursing Facility
63 O.S., Sec. 1-1901, et seq.

Certificate (specify):

None

Other Standard (specify):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- 2) Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Extended State Plan Skilled Nursing

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Extended State Plan Skilled Nursing: Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are ordered by a licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse and are provided by a registered professional nurse or licensed practical nurse licensed to practice in the State.

Extended State Plan Skilled Nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are for treatment of a disease or a medical condition and are beyond the scope of ADvantage Nursing Services. Services are provided when nursing services furnished under SoonerCare plan limits are exhausted. The Oklahoma MMIS forces payment of Medicare, then State Plan Medicaid and then ADvantage to prevent duplication of payment for skilled nurse services.

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

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

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

It is the responsibility of the RN to contact the member's licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse to obtain any necessary information and orders pertaining to the care of the member. If the member has an ongoing need for services that requires more or less units than authorized, the RN shall inform the case manager that the Plan of Care must be revised to accommodate prescribed medical care. If the member does not have a medical provider, the Case Manager will assist the member to access a medical professional of the member's choosing.

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	Skilled Nursing

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Extended State Plan Skilled Nursing

Provider Category:

Agency

Provider Type:

Skilled Nursing

Provider Qualifications

License (specify):

Registered Nurse; Licensed Practical Nurse Licensed under the Nurse Practice Act – 59 O.S. Sec. 567.1 through 567.16

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

Certificate (specify):

None

Other Standard (specify):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Prescribed Drugs

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11060 prescription drugs

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

--	--

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Prescribed drugs available through the approved State Plan will be provided, except that the limitations on amount, duration and scope will be as specified below rather than as specified in the State Plan. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached.

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

Amount, frequency and duration of service is prior authorized. Prescribed drugs available under Medicare Part D to Waiver members who are dual eligible (Medicare/Medicaid) will not be provided under the provisions of this Waiver. Extended state plan prescribed drugs provided through the Waiver are limited to seven (7) prescribed drugs per recipient per month. For waiver recipients who may require more than thirteen (13) prescriptions per month (“brand name” and generic products combined) or who may require more than three (3) “brand name” products per month, a written request may be made on their behalf to have their additional prescription needs reviewed. In addition to a determination of “medical necessity” for the additional prescription product(s) being requested, this review could result in a recommendation that certain medication regimens be altered or discontinued. Recipient co-payments will be required for each monthly prescribed drug. Co- payment amounts will be the same as required for SoonerCare State Plan prescription drug coverage.

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

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Prescribed Drugs

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

Pharmacist
59 O.S. Sec. 353.9, et seq

Certificate (specify):

None

Other Standard (specify):

Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority (OHCA)

Frequency of Verification:

Prior to enrollment and annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Advanced Supportive/Restorative Assistance

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

Advanced Supportive/Restorative Care services are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body function.

Advanced Supportive/Restorative Care is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Supportive/Restorative Care services should be referred to their attending medical provider (licensed medical physician, osteopathic physician, physician assistant or advanced practice nurse) who may, if appropriate, order home health services.

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

- Routine personal care for persons with ostomies (including tracheostomies, gastrostomies and colostomies with well-healed stomas) and external, in-dwelling, and suprapubic catheters which may include changing bags and soap and water hygiene around ostomy or catheter site;
- Remove external catheters, inspect skin and reapplication of same;
- Administer prescribed bowel program including use of suppositories and sphincter stimulation, and enemas (pre-packaged only) with members without contraindicating rectal or intestinal conditions;
- Apply medicated (prescription) lotions or ointments, and dry, non-sterile dressings to unbroken skin;
- Use a lift for transfers;
- Manually assist with oral medications which are set up by a registered or licensed practical nurse (opening of compartments, handing container to Member. ASR assistant may not handle actual medications);
- Provide passive range of motion (non-resistive flexion of joint) delivered in accordance with the plan of care, unless contraindicated by underlying joint pathology; and
- Apply non-sterile dressings to superficial skin breaks or abrasions as directed by a registered or licensed practical 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. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Advanced Supportive/Restorative Assistance

Provider Category:

Agency

Provider Type:

Home Care

Provider Qualifications

License (*specify*):

Home Care License
63 O.S., Sec. 1-1961, et seq.

Certificate (*specify*):

None

Other Standard (*specify*):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- 2) Medicaid Provider Contract
- 3) The ASR Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Health Nurse Aide Registry, name does not appear on the OKOHS Community Services Workers Registry.
- 4) Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.

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

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

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

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

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

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

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

Nurse Supervision Requirements:

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

The registered nurse must:

- Conduct an initial assessment visit and develop the plan of care for members with Advanced

Supportive/Restorative Care needs, in collaboration with the case manager.

- Conduct visits to all Advanced Supportive/Restorative Care members at six-month intervals. During the visit, the RN shall conduct an evaluation of the adequacy of the authorized services to meet the needs and conditions of the member, and shall assess the Advanced Supportive/Restorative Care Aides' ability to carry out the authorized services.
- Make evaluation reports available to the case manager within 48 hours of each evaluation.

Conduct annual assessment/reassessment visits and develop the plan of care for all subsequent years in collaboration with the case manager.

- Attend IDT meetings to establish or amend the Service Plan.
- Be available, at least by telephone, during any time Advanced Supportive/Restorative Care is being provided.
- Observe the successful execution by the aide of each Advanced Supportive/ Restorative Care task during an on-the-job training session or in a lab setting, and certify the successful completion of the task in the aide's personnel record. This visit may be authorized and reimbursed.

The licensed practical nurse may:

- Conduct the quarterly authorized nurse visits to evaluate the condition of the Advanced Supportive/Restorative Care member and forward findings to the RN.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after Enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

02 Round-the-Clock Services

02033 in-home round-the-clock services, other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions. Reviewing service plan requests ensure that duplicative services are not authorized.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Assisted Living

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living Services

Provider Category:

Agency

Provider Type:

Assisted Living

Provider Qualifications

License (specify):

Assisted Living Center 63 O.S. Sec 1-890.1, et seq.

Certificate (specify):

None

Other Standard (specify):

- 1) ADvantage Qualified Provider Certification [OAC 317:30-5-761; see Appendix C-2: 3-10 for standards in addition to licensure]
- 2) In addition, ADvantage certification requires ALs to meet the following Quality Assurance/ Quality Improvement standard:
- 3) The AL shall have a written quality improvement plan that addresses the following:
 - Organizational structure, which includes, but is not limited to the existence of an organization chart and job descriptions;
 - Written Policies and Procedures which provide for a member complaint and grievance process, a member satisfaction evaluation process, employee education and training, and a process for assuring that members are “staffed” and receive the services they have been authorized to receive;
 - A Quality Assurance System which provides for self-audits, member satisfaction evaluation, and corrective action;
 - Management Reports; and
 - Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after Enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer-Directed Personal Assistance Supports and Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08010 home-based habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Consumer-Directed Personal Assistance Services and Support (CD-PASS): CD -PASS consists of Personal Services Assistance and Advanced Personal Services Assistance, optional expense account for allowable goods and services, and administrative financial management services that enable an individual in need of assistance to reside in their home and in the community of their choosing, rather than in an institution and allow the individual to carry out functions of daily living, self-care, and mobility.

Personal Services Assistance (PSA)

The service of Personal Services Assistance may include:

- Assistance with mobility and with transfer in and out of bed, wheelchair or motor vehicle, or both.
- Assistance with routine bodily functions that may include:
 - o Bathing and personal hygiene;
 - o Dressing and grooming;
 - o Eating including meal preparation and cleanup;
- Assistance with housekeeping tasks that may include shopping, laundry, cleaning and seasonal chores; and,
- Companion type service assistance that may include letter writing, reading, mail and providing escort or transportation to participate in approved activities or events;
 - o "Approved activities or events" means community civic participation guaranteed to all citizens such as the exercise of religion, voting or participation in daily life activities in which exercise of choice and decision-making is important to the member. These activities may include shopping for food, clothing or other necessities, or for participation in other activities or events that are specifically approved on the service plan;

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

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

Provider type/mode of service delivery:

- o Personal Care Assistance is provided by a worker (PCA) employed by a licensed Home Care Agency following a plan supervised by a Home Care Agency nurse
- o Personal Services Assistance is provided by a worker (PSA) employed by the member receiving services following a plan supervised by the member

Service definition

- o Self-directed Medicaid services means that participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.
- o Self-direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services. The Centers for Medicare & Medicaid Services (CMS) calls this "employer authority." Participants may also have decision-making authority over how the Medicaid funds in a budget are spent. CMS refers to this as "budget authority."

Scope of services

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

Advanced Personal Services Assistance (APSA)

Advanced Personal Services Assistance are maintenance services provided to assist a member with a stable, chronic condition with activities of daily living when such assistance requires devices and procedures related to altered body

function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the individual were physically capable, and the procedure may be safely performed in the home. Advanced Personal Services Assistance is a maintenance service and should never be used as a therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving Advanced Personal Services Assistance should be referred to their attending physician, who may, if appropriate, order home health services.

The services an Advanced Personal Services Assistance may provide are consistent with the services provided by the Advanced Supportive/Restorative Aide in the home-care agency model.

The APSA is trained by and demonstrates competency of assigned tasks to the member or the member’s representative. When deemed necessary by any member of the IDT, ADvantage Nursing services are authorized to provide assistance with training of the APSA and/or to provide nursing oversight of the delivery of APSA services

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

Goods and Services

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

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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	Advanced Personal Services Assistant
Individual	Personal Services Assistant

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consumer-Directed Personal Assistance Supports and Services

Provider Category:

Individual

Provider Type:

Advanced Personal Services Assistant

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

- Medicaid Provider Contract
- The Assistant is at least 18 years of age, has not been convicted of a crime as defined in 63 O.S., Sec. 1-1950 et seq., has no pending notation of abuse or neglect as reported by the Oklahoma State Department of Health Nurse Aide Registry, name does not appear on the OKOHS Community Services Workers Registry, OHS Child Care Restricted Registry, Oklahoma Sex Offender and/or Violent Offender Registries.
- Demonstrates the ability to understand and carry out assigned tasks, has verifiable work history and/or personal references, has verifiable identification.
- Training Requirements: Demonstrates competence to perform required tasks to employer/participant satisfaction. When deemed necessary by any member of the IDT, ADvantage Nursing services are authorized to provide assistance with training of the APSA and/or to provide nursing oversight of the delivery of APSA services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Employer/Participant is responsible for verifying Employee information and training. The contracted FMS completes the criminal and abuse registry background checks on behalf of the Employer/Participant and the FMS makes the Employer/Participant aware of findings.

Frequency of Verification:

Prior to enrollment and re-verified as necessary

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consumer-Directed Personal Assistance Supports and Services

Provider Category:

Individual

Provider Type:

Personal Services Assistant

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard (specify):

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

Training Requirements: Training provided by employer/participant to the personal services assistant, regarding specific tasks to perform. Demonstrates competence to perform required tasks to employer/participant satisfaction.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Employer/Participant is responsible for verifying Employee information and training. The contracted FMS completes the criminal and abuse registry background checks on behalf of the Employer/Participant and the FMS makes the Employer/Participant aware of findings.

Frequency of Verification:

Prior to enrollment and re-verified as necessary

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Environmental Accessibility Modifications are physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization.

Adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, and installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the individual, and which include construction, reconstruction, or remodeling of any existing construction in the home (floors, sub-floors, foundation work, roof, or major plumbing).

Services not covered under architectural modifications include:

- Installation of heating or air conditioning units;
- Humidifiers;
- Water softener units;
- Fences;
- Sun rooms;
- Porches or decks;
- Canopies;
- Covered walkways;
- Driveways;
- Sewer lateral lines or septic tanks;
- Foundation work
- Room additions;
- Carports;
- Non-adapted home appliances;
- Carpet or floor covering that is not part of an approved architectural modification that requires and includes a portion of the floor to be re-covered, such as a roll in shower or door widening;
- A sidewalk is not authorized unless needed by the member to move between the house and vehicle; and
- Adaptations which add to the total square footage of the home are excluded from this benefit.

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

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

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

Amount, frequency and duration of service are prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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	Plumbers
Individual	Engineers
Individual	Re-modelers and Builders
Individual	Mechanical Contractors
Individual	Architects
Individual	Electrician

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Plumbers

Provider Qualifications

License (*specify*):

Plumbing Licensing Act, 59 O.S., Sec. 1001-1021

Certificate (*specify*):

None

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Engineers

Provider Qualifications

License (specify):

An Act Regulating Professional Engineers and Land Surveyors, 59 O.S., Sec. 475.1 et seq.

Certificate (specify):

None

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Re-modelers and Builders

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Mechanical Contractors

Provider Qualifications

License (specify):

Mechanical Licensing Act, 59 O.S., Sec. 1850.1-1850.15

Certificate (specify):

None

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Architects

Provider Qualifications

License (specify):

Architects Oklahoma Administrative Code Title 55, Chapter 10

Certificate (specify):

None

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Environmental Accessibility Modifications

Provider Category:

Individual

Provider Type:

Electrician

Provider Qualifications

License (specify):

Electricians Licensing Act, 59 O.S., Sec. 1680 et seq.

Certificate (specify):

None

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home-Delivered Meals

HCBS Taxonomy:

Category 1:

06 Home Delivered Meals

Sub-Category 1:

06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (*Scope*):

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

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

The goals of Home-Delivered Meals

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

In order to receive Home-delivered Meals under the waiver, a member must:

- (1) Be unable to prepare some or all of his/her own meals, or requires a special diet and is unable to prepare meals; or
- (2) Have no other individual available to prepare member's meals, or the provision of a Home-delivered Meal is the most cost-effective method of ensuring a nutritionally adequate meal.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan; however, one (1) meal is the maximum number of meals per day allowed.

Safeguards:

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

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home-Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home-Delivered Meals

Provider Category:

Agency

Provider Type:

Home-Delivered Meals

Provider Qualifications

License (*specify*):

Oklahoma Health Code, Food Preparers/Handlers License – Sec. 1110 & 1119 59 O.S. Sec. 21 or equivalent Food Preparers License from the state where the kitchen facility is located.

Certificate (*specify*):

County Health Department Kitchen Cert & Food Handlers Certification, or equivalent Certification from the state where the kitchen facility is located, or evidence that the kitchen is USDA inspected and approved.

Other Standard (*specify*):

ADvantage Qualified Provider Certification [OAC 317:30-5-761].
 Medicaid Provider Contract.
 Title III Program Home-Delivered Meal Provider Standards.
 Comply with all applicable Federal, State, and Local laws and ordinances regulating the preparation handling and distribution of food.

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Hospice Care

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage Hospice services.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Initial authorization is for a maximum of six months. The total annual service plan authorization may not exceed 85% of the preceding year's Medicare annual cap payment amount.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Hospice Care

Provider Category:

Agency

Provider Type:

Hospice Agency

Provider Qualifications

License (*specify*):

63 O.S. 1991, Sec. 1-860 et seq.

Certificate (*specify*):

Medicare Hospice certification

Other Standard (*specify*):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Institution Transition Services

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

Institution Transition Services includes:

- Transitional Case Management – Standard and Very Rural

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

Reimbursement for Institution Transition Case Management services is only made if the individual returns from the institution to their home with ADvantage services within 180 days.

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

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

Transition Case Management Services may be utilized for periodic monitoring of an ADvantage member's progress during an institutional stay, and for assisting the member transition from institution to home by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution. Transition Case Management Services may also be authorized to assist ADvantage-eligible members that have not previously received ADvantage services to transition from the institution to the community with ADvantage services support.

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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

Participant-directed as specified in Appendix E

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Institution Transition Services

Provider Category:

Agency

Provider Type:

Case Management

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

ADvantage Qualified Provider Certification [OAC 317:30-5-761]

- Medicaid Provider Contract
- Minimum qualifications for Case Manager are:
 1. RN with one year paid professional experience; or
 2. LPN with one year paid professional experience; or
 3. Baccalaureate degree and one year *paid professional experience with the aging or disabled population obtained before or after receipt of degree; and,

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

A minimum of one week of orientation to the agencies policies and procedures to include shadowing a certified Case Manager in the field. (Documentation of orientation to be submitted to the MSU before the ADvantage CM Training date)

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nursing

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse or licensed practical nurse licensed to practice in the State. . The provision of nursing services will prevent institutionalization of the member.

Skilled Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended as treatment for an acute health condition and may not include services that would be reimbursable as skilled nursing care under either Medicare or Medicaid home health programs. Should the nurse detect a need for services that would meet the definition of reimbursable skilled nursing care he/she must alert the member's physician and case manager for service coordination.

The ADvantage Assessment and Evaluation (A&E) Registered Nurse's primary role is to assess the member's health and safety, develop and implement the personal care plan, provide training and supervision to the Personal Care Assistant and/or Advanced Supportive/Restorative aide, and provide ongoing assessment of the suitability of the care plan to meet the member's needs. This is accomplished through the Interdisciplinary Team (IDT) planning process which includes the member, Case Manager, and other members of the IDT as appropriate. It is the responsibility of the A&E RN to attend IDT meetings required to develop or amend the Plan of Care.

To comply with the Oklahoma Home Care Act, an initial A&E RN evaluation must precede personal care service delivery, must be a component of both the initial assessment and annual reassessment processes supporting development of the plan of care for personal care services, and must be performed by the entity that provides personal care services in the home care provider model. To promote continuity of care and timely service delivery, the ADvantage Program regards an agreement by a provider to produce a nurse evaluation as an agreement, as well, to provide those Medicaid in-home care services identified by the assessment/reassessment that the provider is certified and contracted to provide. Reimbursement for a nurse evaluation shall be denied if the provider that produced the nurse evaluation fails to provide the Medicaid in-home care services identified by the assessment when the provider is certified and contracted to provide those services.

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

Skilled Nursing services may include (but is not limited to) one or more of the following where appropriate to the needs of the member as authorized by the ADvantage Program OHS Medicaid Services Unit:

- Filling insulin syringes for a visually impaired diabetic who can self-inject the medication but cannot fill his own syringe. This service would include monitoring the member 's continued ability to self-administer the insulin;
- Setting up oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to disorientation/confusion, visual deficit, limited mobility or other limitations;
-
- Monitoring a member's skin condition when a member is at risk of skin breakdown due to immobility or incontinence or the member has a chronic impairment of skin integrity requiring maintenance care and assessment;
- Conducting general health evaluations;
- Providing nail care for a member with diabetes, circulatory, neurological, vision, cognitive or mobility deficits;
- Provide on-the-job training and competency testing for Advanced Supportive/Restorative Assistants.
- Provide to the case manager a copy of each Nursing Evaluation (within 24 hours) or monitoring visit (within 48 hours).

It is the responsibility of the RN to contact the member's physician to obtain any necessary information and orders pertaining to the care of the member. If the member has an ongoing need for services that requires more or less units than authorized, the RN shall inform the case manager that the Plan of Care must be revised to accommodate the member's health care needs.

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. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nursing

Provider Category:

Agency

Provider Type:

Home Care

Provider Qualifications

License (specify):

Registered Nurse; Licensed Practical Nurse licensed under the Nurse Practice Act – 59 O.S. Sec. 567.1 through 567.16

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

Certificate (specify):

None

Other Standard (specify):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Personal Emergency Response System (PERS) is an electronic device which enables individuals at high risk of institutionalization to secure help in an emergency. The individual may 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 are without capable assistance by someone in the home; who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who have a recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted. In addition, the member must demonstrate capability to comprehend the purpose of the PERS and ability to activate the PERS, have a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home, and have a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls.

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

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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	Medical & Rehabilitative Equipment Manufacturers and Suppliers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Emergency Response Systems

Provider Category:

Agency

Provider Type:

Medical & Rehabilitative Equipment Manufacturers and Suppliers

Provider Qualifications

License (specify):

None

Certificate (specify):

None

Other Standard (specify):

•Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

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

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

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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	Medical & Rehabilitative Equipment Manufacturers and Suppliers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical & Rehabilitative Equipment Manufacturers and Suppliers

Provider Qualifications

License (specify):

None

Certificate (specify):

Medicare Certification

Other Standard (specify):

- Advantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract
- Oklahoma Medical Practice Act - 59 O.S., Sec. 481 through 536

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Health Care Authority (OHCA)

Frequency of Verification:

Prior to Enrollment and prior to re-contracting

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Therapy Services

HCBS Taxonomy:

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11080 occupational therapy

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

11090 physical therapy

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

SKILLED THERAPY SERVICES

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

1. The development, implementation, management, and evaluation of an individual care plan based on the physician's orders constitute skilled therapy services when, because of the member's condition, those activities require the involvement of a skilled therapist to meet the member's needs, promote recovery, and ensure medical safety. When the skills of a therapist are needed to manage and reevaluate periodically the appropriateness of a maintenance program because of an identified danger to the member, such services would be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

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

The skills of a therapist are needed to establish a reasonable and necessary maintenance program until it can be safely and effectively carried out by nonskilled individuals. If a danger to the member's safety warrants the skills of a therapist to management and reevaluate periodically the appropriateness of the maintenance furnished, the services may be covered because the program is not yet fully established for safety and effectiveness.

2. The skilled therapy services must be reasonable and necessary to the treatment of the member's illness or injury within the context of the member's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

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

If there is not a reasonable expectation of improvement in a member's condition, there may still be a need for skilled services to establish a maintenance program. A special medical complication might also necessitate skilled services to perform exercises or treatments that are normally considered nonskilled, even when no rehabilitation potential is present.

d. Services of skilled therapists which are for the purpose of teaching the member or the member's family or caregivers necessary techniques, exercises, or precautions are covered to the extent that they are reasonable and necessary to treat the illness or injury. However, visits made by skilled therapists to the member's home solely to train other home health agency staff (e.g., home health aides) are not billable as visits since the home health agency is responsible for ensuring that its staff is properly trained to perform any services it furnishes. The cost of a skilled therapist's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

The following Skilled Therapy Services are covered:

- Physical Therapy;
- Occupational Therapy;

Physical Therapy Services

Service Definition: Physical Therapy services are those that prevent physical disability through the evaluation and rehabilitation of individuals disabled by pain, disease or injury. Services are provided in the member's home or ADH

and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as: massage, manipulation, therapeutic exercise, cold heat, hydrotherapy, electrical stimulation and light. Under the Physical Therapy Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate written therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) days. Any treatment required after the thirty day period shall require a physician's prescription.. The therapeutic regimen may utilize a paraprofessional physical therapy assistant services within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the recipient's rehabilitative progress and will report to the recipient's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

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

Physical Therapy Service Components:

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

Occupational Therapy Services

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

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

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

- a. Selecting and teaching task-oriented therapeutic activities designed to restore physical function.
- b. Planning, implementing, and supervising therapeutic tasks and activities designed to restore sensory-integrative function.
- c. Teaching compensatory techniques to improve the level of independence in the activities of daily living.
- d. The designing, fabricating, and fitting of orthotic and self-help devices.

Vocational and prevocational assessment and training which are directed toward the restoration of function in the activities of daily living lost due to illness or injury. When vocational or prevocational assessment and training are related solely to specific employment opportunities, work skills or work settings such services would not be covered because they would not be directed toward the treatment of an illness or injury.

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

or delay the permanent institutionalization of an individual.

Occupational Therapy Service Components:

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

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

Amount, frequency and duration of service is prior authorized in accordance with service plan. Prior authorization is completed by Oklahoma Human Services staff during review of all service plan submissions.

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
Individual	Physical Therapist
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapy Services

Provider Category:

Agency

Provider Type:

Home Care

Provider Qualifications

License (*specify*):

63 O.S., Sec 1-1961, et seq.

Certificate (*specify*):

None

Other Standard (*specify*):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License (*specify*):

59 O.S. Sec. 887.1, et seq.

Certificate (*specify*):

None

Other Standard (*specify*):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Therapy Services

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License (*specify*):

59 O.S. Sec. 888.1, et seq.

Certificate (*specify*):

None

Other Standard (*specify*):

- ADvantage Qualified Provider Certification [OAC 317:30-5-761]
- Medicaid Provider Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

Oklahoma Human Services (OHS)

Frequency of Verification:

Prior to Enrollment and Annually after enrolled

Appendix C: Participant Services

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

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

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

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

Check each that applies:

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

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

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

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

As a primary care case management system service under a concurrent managed care authority. Complete item C-1-c.

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

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

In addition, fifty-five other agencies are for-profit organizations. Of these, thirty-three provide home care services.

Appendix C: Participant Services

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

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

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

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

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

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

Proof of OSBI background check must be documented in the provider personnel record. Evaluation of documentation of OSBI background check prior to hire is a standard component of license review inspections by the Oklahoma State Department of Health of Home Care Agencies and Adult Day Care Centers.

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

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

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

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

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

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

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Nursing Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Emergency Response Systems	
Specialized Medical Equipment and Supplies	
Home-Delivered Meals	
Nursing	
Assisted Living Services	
Environmental Accessibility Modifications	
Prescribed Drugs	
Institution Transition Services	
Hospice Care	
Consumer-Directed Personal Assistance Supports and Services	
Personal Care	
Extended State Plan Skilled Nursing	
Advanced Supportive/Restorative Assistance	

Waiver Service	Provided in Facility
Therapy Services	
Adult Day Health	
Case Management	
Respite	

Facility Capacity Limit:

N/A

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

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Services and Supports Provided by a Legally Responsible Individual

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

Authorization for a spouse or legal guardian to be the care provider for a member may occur only when the member is offered a choice of providers and documentation demonstrates:

- 1) no provider on the Certified Agency Report (CAR) has available staffing; or
- 2) the member's needs are so complex that unless the spouse or legal guardian provides the care, the member's risk level would increase; and
- 3) it is mentally or physically detrimental for someone other than the spouse or legal guardian to provide care.

The service must:

- (i) meet the definition of a service/support;
- (ii) be necessary to avoid institutionalization;
- (iii) be a service/support specified in the person-centered service plan;
- (iv) be provided by a person who meets the provider qualifications and training standards specified for that service;
- (v) 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 OHCA for the payment of personal care or personal assistance services; and
- (vi) not be an activity the spouse or legal guardian would ordinarily perform or is responsible to perform.

The spouse or legal guardian service provider complies with:

- (1) providing no more than forty (40) hours of services in a seven-day (7-day) period;
- (2) planned work schedules that must be available in advance for the member's case manager, and variations to the schedule must be noted and supplied to the case manager two (2) weeks in advance unless the change is due to an emergency;
- (3) maintaining and submitting time sheets and other required documentation for hours paid; and
- (4) the person-centered service plan as the member's care provider.

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

Monitoring Requirements:

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

- 1) at least quarterly reviews with the OHS MSU of expenditures, and the health, safety, and welfare status of the individual recipient;
- 2) Case Management visits with the recipient on at least a monthly basis;
- 3) Monthly reviews by the Case Management provider of hours billed for spouse or guardian provided care.

Self-directed

Agency-operated

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

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

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

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

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

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

Personal Care services are intended to supplement and support existing informal care and the use of informal supports as Personal Care Attendants may jeopardize the informal support system. In the ADvantage Program, the relevant issue is not whether the person being hired to provide personal care/assistance services is a relative as much as whether the person being hired is already a part of the informal support system providing services informally and without compensation.

Prior to agreeing to permit employment of relatives or other persons who are already providing informal supports, the interdisciplinary team takes the following into consideration:

The member has been offered a choice of providers and documentation demonstrates that:

- Either no other provider is available; or,
- Available providers are unable to provide necessary care to the member, or

In the team's judgment, employment of the relative/informal provider as a paid provider will not overburden the individual so employed and ultimately be destructive to maintaining member supports.

Controls employed to ensure that payments are made only for services rendered are the same as applied to all providers:

- Units are authorized on the service plan consistent with tasks required to meet member needs;
- Time record documentation of service delivery is required of all direct care providers; Provider audits review documentation for compliance of delivery of services to authorization as required.

Monitoring requirements: In addition to the standard Case Management monitoring and reporting activities required for all waiver services, the state obligates Case Management to make a home visit to the member monthly when an existing informal support becomes a paid service provider.

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 certified to provide services for the ADvantage Waiver can submit their application information through the ADvantage WMIS system. Providers requesting certification to provide ADvantage Case Management, Home Care, Home Delivered Meals, Adult Day Health, Assisted Living or Hospice services are advised that they will be contacted when the next public meeting will be held. All other Provider types requesting certification to provide ADvantage services are directed to the WMIS system to access all documents to be read, completed, signed, and returned to the MSU for approval.

A public meeting is held quarterly to advise potential new providers about the ADvantage Program. All potential Providers receive direction on completing the application documents and receive submission timeframes to become a certified ADvantage provider.

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

The Medicaid Services Unit (MSU) ensures that potential providers have completed and signed the appropriate waiver documents for each service they provide and have completed all contractual documents as required by OHCA. New Provider Orientation is required for Home Care, Case Management, Home Delivered Meals, Adult Day Health, Assisted Living, and Hospice service providers. New Provider Orientation gives potential providers information regarding the MSU and ADvantage Administration. Each department is represented and explains their contribution to the ADvantage program. Conditions of Provider Participation and Services Standards are presented and explained in detail during this orientation. Specific information, based on service type, is also provided to each individual group.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and Percent of all licensed/certified providers that initially met all licensure/certification standards and requirements prior to furnishing waiver services. Numerator: Number of all licensed/certified providers that initially met all licensure/certification standards and requirements prior to furnishing waiver services. Denominator: Total number of all licensed/certified providers.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

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

Performance Measure:

Number and Percent of licensed/certified providers that continue to meet all licensure/certification standards and requirements. Numerator: Number of licensed/certified providers that continue to meet all licensure/certification standards and requirements. Denominator: Total number of licensed/certified providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

	Continuously and Ongoing	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>
	Other Specify: <input style="width: 100px; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:

Number and Percent of all new non-licensed/non-certified providers who met all waiver qualifications prior to providing waiver services. Numerator: Number of all new non-licensed/non-certified providers who met all waiver qualifications prior to providing waiver services. Denominator: Total number of all new non-licensed/non-certified providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percentage of non-licensed/non-certified providers that continue to meet all standards and requirements after initial enrollment. Numerator: Number of non-licensed/non-certified providers that continue to meet all standards and requirements after initial enrollment. Denominator: Total number of non-licensed/non-certified providers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

For each performance measure 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 new Case Managers that successfully complete required training conducted in accordance with state requirements and the approved waiver.

Numerator: Number of new Case Managers that successfully complete required training conducted in accordance with state requirements and the approved waiver.

Denominator: Total number of new Case Managers.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OHS dedicated waiver staff are responsible for program monitoring and oversight and will address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures.

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

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

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

OHS Provider Certification staff monitor that certifications of providers as qualified are performed in accordance with waiver and Medicaid Agency policy. If any instances are found in which a provider furnished ADvantage services prior to meeting all standards and requirements, or in which an enrolled provider failed to continue to meet standards and requirements after initial enrollment, or in which any active ADvantage Case Manager failed to meet training requirements, the OHS MSU Program Administrator contacts the appropriate Provider and OHS Provider Certification staff for resolution. If deemed necessary, Provider Certification staff will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the Medicaid Services Unit (MSU).

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

OHS will provide reports of remediation and corrective action plans (if any) to the OHCA QMSC.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

[Empty text box]

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.

[Empty text box]

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.

[Empty text box]

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

Describe the limit and furnish the information specified above.

[Empty text box]

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

Please Refer to Main, Attachment#2

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

ADvantage Participant -Centered Service Plan

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

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

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

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

In accordance with 42 CFR 431.301(c)(1)(vi), OHS MSU will not authorize services for agencies that develop the person-centered plan and provide services except in the following circumstances:

- OHS MSU has demonstrated to CMS that the only willing and qualified case manager is also affiliated with a direct service provider. In demonstrating such, OHS MSU affirms they will exhaust all avenues of securing providers that are not directly affiliated.
- Furthermore, providers are restricted from developing the person center service plan and providing services without the direct approval of OHCA.

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

- All participants are informed that they have freedom of choice of providers and that they may change providers at any time.
- Service plans are reviewed by an MSU Clinical Review Nurse prior to approval with regard to both the service plan and corresponding service units to ensure they are appropriate to meet the member's assessed needs.
- In the event the member's county of residence does not afford an alternative provider agency to support the member's needs, the case manager documents the issue and submits the case to MSU Clinical Review staff for review to determine if a conflict in the delivery of service(s) will occur.
- At that time, if a conflict in the delivery of service(s) will occur, the MSU escalated issues team will work with the Case Manager directly to ensure the Service Plan Goals provide detail and clarity to address the conflict between Case Management and provider provision of service, and to ensure the Case Manager documents the service need as addressed in the conditions of provider participation to alleviate and mitigate the potential for the conflict to have an untoward outcome, and assure appropriate safeguards for the Member.
- OHCA restricts the entity that develops the person-centered service plan from providing services without the direct approval of OHS MSU.
- OHS MSU requires the agency that develops the person-centered service plan to administratively separate plan development functions from the direct service provider functions. The Case Manager cannot provide nursing services, personal care services, or be the supervisor of the person providing nursing or personal care services. The Nurse Supervisor and/or the Personal Care Supervisor cannot be the same person as the Case Manager Supervisor. All plans are submitted to, and reviewed by, Service Plan Analysts prior to service authorization to assure provider agency staff responsible for development of the person-centered service plan have no administrative responsibility for direct service provider functions.

In the event a participant disputes the states assertion that there is not another entity or individual that is not the member's provider to develop the person-centered plan, the participant and OHS MSU Escalated Issues staff will engage in a clear and accessible alternative dispute resolution process.

The MSU maintains a toll-free CareLine to register member, family or provider complaints, problems and/or incidents. As part of orientation to the waiver, each member is provided information about the toll-free number through a New Member letter sent from the MSU as well as by the case manager. MSU Resource Center staff will review and assign the complaint, problem and/or incident to the appropriate waiver staff to investigate, track and record actions and resolution for each complaint or incident.

Quality of service delivery of all providers is monitored by MSU Provider Certification and QIS staff. Individualized reports for provider complaints/incidents are retained for tracking purposes to identify potential patterns that may alert the MSU of quality problems with individual providers.

Appendix D: Participant-Centered Planning and Service Delivery

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

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the

service plan development process and (b) the participant's authority to determine who is included in the process.

One of the foundational modules in the ADvantage Case Management Training is Interdisciplinary Teams (IDT). This module is designed to educate case managers about the IDT approach to service planning and to emphasize the philosophy of seeing the “whole” person through a variety of perspectives. This module educates case managers that members, and/or the members’ 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 to identify who the member would like to invite to the team table.

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

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

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

- 1) **Principle #1 Case Management is Participant Centered:** Case Management is a Participant-centered service that respects Participants’ rights, values and preferences.
- 2) **Principle #2 Case Management Coordinates ALL Assistance:** Case Management coordinates all and any type of assistance to meet identified Participant needs including those related to the transition process and those related to community living.
- 3) **Principle #3 Case Management requires knowledge, skills & competencies:** To perform well, case managers require specialized clinical skills, knowledge, and personal characteristics and competencies.
- 4) **Principle #4 Case Management promotes quality:** Case management promotes the quality of services provided.
- 5) **Principle #5 Case Management is goal oriented:** Case management is forward looking and makes plans to reach member defined goals based on today’s indicators.
- 6) **Principle #6 Case Management uses resources efficiently:** In the prescription of services to meet, but not to exceed, assessed need and to efficiently coordinate services, case management is a cost-effective service.

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. Participants in the service planning team are selected by the member and may include the member’s family, legal representatives, advocates, friends and support personnel from other provider agencies.

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

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

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

The MSU shall ensure that a written Service Plan is developed for each eligible member that wants to participate in the waiver program.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

The person-centered service plan is based on the member's service needs as identified by the UCAT Part III and the ADvantage nursing assessment. The service plan incorporates, to the extent possible, non-waiver services to meet member needs. Non-waiver community-based services include, but are not limited to, Medicare, Medicaid State Plan, Veterans services, United Way and/or other community furnished services. For the ADvantage service portion of the service plan, the plan includes only those ADvantage services required to sustain and/or promote the health and welfare of the member. The case manager uses an interdisciplinary team (IDT) planning approach for service plan development. If in-home care is part of the service plan, the IDT includes, at a minimum, the member, a nurse from the ADvantage in-home care provider chosen by the member, and the case manager. Otherwise, the member and case manager constitute a minimum IDT.

The case manager identifies long-term goals and challenges to meeting goals. The person-centered service plan includes identified needs and planned services to meet those needs. For each service, the case manager identifies service providers, funding sources, units and frequencies of service, service costs. The member signs and indicates review/agreement with the service plan by indicating acceptance or non- acceptance of the plan. The member, the member's legal guardian or legally authorized representative shall sign the service plan in the presence of the case manager. The signatures of two witnesses are required when the member signs with a mark. If the member refuses to cooperate in development of the service plan, or, if the member refuses to sign the service plan, the case management agency refers the case to the MSU for resolution. In addition, based on the UCAT and/or case progress notes that document chronic uncooperative or disruptive behaviors, the LTC nurse or MSU may identify members that require MSU intervention.

- (1) Upon receipt of an ADvantage referral from the Medicaid Services Unit (MSU), the case management supervisor assigns a case manager to the member. When the assignment is received, the Case Manager contacts the member to arrange to meet in the member's home or at another location chosen by the member and at a time convenient for the member. After being assigned an ADvantage member, the case manager makes a home visit to review the ADvantage program (its purpose, philosophy, and the roles and responsibilities of the member, service provider, case manager, MSU and OHS in the program), and review, update and complete the UCAT assessment, and discuss service needs and ADvantage service providers.
- (2) In accordance with OHS Policy (317:35-17-14), the case manager completes and submits to the MSU an individualized service plan for the member. The case manager submits the signed plan to the Case Manager Supervisor, who then reviews and submits to the MSU. For reassessment, the annual service plan is initiated no sooner than 60 days before the existing service plan end date but sufficiently in advance of the end date to be received by the MSU at least 30 calendar days before the end date of the existing service plan.
- (3) In accordance with OHS policy (317:35-17-14), the Case Manager provides updated care plan and service plan documentation. Within five calendar days of assessed need, the case manager completes and submits a service plan addendum to the MSU to amend current services on the care plan and service plan.
- (4) This is stated above....The case manager submits the service plan to the case management supervisor for review. In accordance with OAC 317:35-17-14, the case management supervisor documents the review/approval of the plans of receipt from the case manager or returns the plans to the case manager with notations of errors, problems, and concerns to be addressed. In accordance with OAC 317:35-17-14, the case manager re-submits the corrected care plan and service plan to the case management supervisor. The case management supervisor returns the approved care plan and service plan to the case manager. In accordance with OAC 317:35-17-14, after receiving supervisory approval, the case manager forwards, via postal mail, a legible copy of the care plan and service plan to the MSU. Case managers are responsible for retaining all original documents for the member's file at the agency. Only priority service needs and supporting documentation may be faxed to the MSU with the word, "PRIORITY" being clearly indicated and the justification attached. "Priority" service needs are defined as services needing immediate authorization to protect the health and welfare of the member and/or avoid premature admission to the nursing facility. Corrections to service conditions set by the MSU are not considered to be a priority unless the health and welfare of the member would otherwise be immediately jeopardized and/or the member would otherwise require premature admission to a nursing facility.
- (5) In accordance with OAC 317:35-17-14, the case manager ensures providers are in receipt of the copies of the authorized service(s) by communicating with the service plan providers to facilitate service plan implementation.
- (6) Within five working days of notification of an initial or new service plan authorization, the case manager contacts the member via the member's chosen method of communication to and evaluate service plan implementation.
- (7) The case manager contacts the Member to monitor and evaluate the adequacy of the service plan on the following

minimum schedule:

- (A) Within 5 working days of receipt of an authorized service plan for new and/or revised ADvantage services, sends the member a copy of the service plan or computer-generated copy of the service plan, copy of approved service plan goals and evaluate service plan implementation;
- (B) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
- (C) monthly after the initial 30 day follow-up evaluation date.

Change in service plan. The process for initiating a change in the service plan follows:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

OHS Medicaid Services Unit (MSU) conducts case management training for all case managers and provides basic knowledge and tools to enable case managers to assess appropriately and develop Service Plans which adequately address issues of risk and risk mitigation.

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

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

- UCAT Mental Status Questionnaire (MSQ) score over 18, without evidence of 24 hour supervision/support.
- Lives alone with MSQ over 12.
- History of falls without evidence of fall prevention plan in goals.
- Evidence of wounds.
- Medication management issues.
- Ventilator dependent.
- Oxygen dependent
- Documentation of potential abuse, neglect or exploitation.
- APS involvement.
- Unable to transfer or evacuate the home independently.
- Unable to ambulate without assistance and is left alone for periods of time.
- Unable to use telephone or PERS (Personal Emergency Response System) device.
- Need for 24 hour support is documented but is not provided per Service Plan.
- Severe mental health conditions / risk of harm to self or others.
- Significant environmental hazards are identified by assessor.
- Requests for excessive personal care and / or ASR service.

Service Plans with any of the above indicators are forwarded for a clinical review to be completed by a registered nurse. Plans are then reviewed in detail for addressing identified indicators. Outcome of the reviews are as follows:

- Service Plan is determined to have addressed all identified risk factors, no further action is taken.
- Service Plan has not addressed risk factors; condition is placed on the case management service authorization requesting documentation to address those issues; The case management provider must submit revised documentation to address issues of concern in order for case management services to be approved for reimbursement.
- Identified issues are significant enough to warrant escalation to Escalated Issues Team. An Escalated Issues team member investigates the issue by contacting the case manager. Collaboration then occurs between team members and departmental management to ensure issues are appropriately addressed or resolved. When necessary, issues are forwarded to the ADvantage Ethics of Care Committee for guidance and/or administrative determinations.

Because members are supported in their own private residence or other settings where staff are not continuously available, all members are required to have Backup Plans that include a minimum of the following services:

1. Direct service worker
2. Critical health or supportive services
3. Equipment repair or replacement.

For each back-up plan, the provider agency that is to furnish staff support on an on-call basis as necessary is the first tier of back-up support. For the CD-PASS member, this back-up support may be an identified alternate care provider or an agency provider. As a secondary tier, the member's informal supports may give their consent to provide the critical

service in the event it is needed for the member. The third tier back-up support is the member's Case Manager who may arrange temporary alternate community services or supports. For extreme emergencies that rise to the fourth tier level, the 9-1-1 emergency statewide call system is to be used.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the assessment for nursing facility level of care, the OHS MSU Eligibility nurse informs the member and family of agencies certified to deliver ADvantage Case Management and in-home care services in the local area to obtain the member's primary and secondary informed choices. The Eligibility nurse educates the member and family that providers of Case Management services may not provide any other ADvantage services in order to avoid a conflict of interest. The nurse documents the names of the chosen agencies and the agreement of the member (by dated signature) to receive services provided by those agencies. If the member or his/her legal representative have no preference of provider(s), the nurse documents this information. If the Member had no preference for either Case Management, Home Care or both, the MSU initiates a rotating system to select an agency (Case Management, Home Care or both) for the member from a list of ADvantage certified/contracted case management and in-home care agencies providing services in the area in which the member resides, in keeping with conflict free requirements.

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

As a regular function of monitoring the member, the Case Manager consults with the member about satisfaction with services and service providers. The Case Manager furnishes information whenever the member requests information about available service providers.

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 OHS Medicaid Service Unit (MSU) authorizes the individual service plan and all service plan amendments for each ADvantage member using established protocols and criteria. The MSU Service Plan Authorization unit (SPA) reviews/authorizes the initial service plan and all subsequent amendments and reassessments for each member enrolled in ADvantage.

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

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

MSU/SPA staff document authorized service plans on the Waiver Management Information System (WMIS). Prior Authorizations are generated from WMIS for individual services and posted on the Medicaid Management Information System.

All waiver service plans are subject to review and approval by the OHS/MSU.

OHS, in partnership with the Oklahoma Health Care Authority (OHCA), may review any service plan deemed necessary by the operating agency in the Quality Management Strategy Committee (QMSC) meeting. Referral may also be made to the OHCA medical team for review/opinion of the Risk Assessment and Mitigation plan.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

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

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

Within five business days of notification of an initial or new service plan authorization, the case manager contacts the member via the member's chosen method of communication to evaluate service plan implementation. Thereafter, the Case Manager evaluates service plan implementation on the following minimum schedule:

- (A) within 30 calendar days of the authorized effective date of the service plan or service plan addendum amendment; and
- (B) Monthly thereafter.

The monthly monitoring may be conducted by phone 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. This standard is reflected through the agency's commitment of sufficient implementation resources, supervision activities, documentation practices and management reports.

Minimum Components of Agency Policies and Procedures

- A. The case management agency identifies high risk members according to ADvantage guidelines.
- B. The case manager addresses High Risk needs in the member's person-centered Service Plan.
- C. The case management agency provides heightened supervisory and administrative scrutiny of high risk members through enhanced monitoring activities.

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

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

b. Monitoring Safeguards. *Select one:*

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

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

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

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

1. All participants are informed that they have freedom of choice of providers and that they may change providers at any time.
2. ADvantage Program certification Conditions of Provider Participation (COPP) requires each Case Management provider to provide an accessible means for members to register complaints and a process for provider follow-up action to resolve complaints and address member identified problems. The system must track and report on provider performance and member satisfaction with services and provide a process that the provider uses to regularly assess and develop interventions to try to improve provider performance. ADvantage Program provider audits assess provider compliance with COPP and with provider Service Standards.
3. At a systems level, the MSU maintains a Resource Center and Escalated Issues team to register member, member family or provider/case manager complaints, problems or incidents. The Resource Center is accessed via a toll-free 800 number. As part of orientation, each member is provided information about Resource Center and the 800 number by the Case Manager. The Resource Center is supported by a database system to track complaints/incidents, to support MSU assignment of Escalated Issues team to investigate, track resolution process and record actions and resolution for each complaint or incident.
4. Quality of service delivery performance of all providers is monitored by the MSU (Provider Audit, Resource Center, Escalated Issues and Provider Question teams). Individualized reports for provider complaint/incident are produced for complaint/incident tracking by Case Management providers. These reports are utilized to identify patterns of incident or problem types requiring attention or patterns of complaints/incidents that may alert the MSU of potential quality problems with individual providers. MSU shares complaint/incident reports resulting from all sources and including Provider Audit reports with the OHCA and the OHCA participates in Quality Management Strategies Council (QMSC) meetings in which complaint/incident and Provider Audit reports are reviewed and trends and/or major issues are addressed.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and Percentage of Member Service Plans that address Members' assessed needs (including health and safety) and personal goals. Numerator: Number of Member Service Plans that address Members' assessed needs (including health and safety) and personal goals. Denominator: Total number of Member Service Plans reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 30px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 30px;" type="text"/>

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:

Number and Percentage of member service plans revised when warranted by significant changes in the member’s needs. Numerator: Members with service plan revised when warranted by significant changes in the member’s needs. Denominator: Members with progress notes indicating significant need for service revisions.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level with a +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of reassessment service plans updated annually and submitted at least 30 days prior to the member's annual service plan end date. Numerator: Number of reassessment service plans updated annually and submitted at least 30 days prior to the member's annual service plan end date. Denominator: Number of reassessment service plans reviewed.

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

		<p>Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level with a +/- 5% margin of error</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (<i>check each that applies</i>):</p>	<p>Frequency of data aggregation and analysis(<i>check each that applies</i>):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

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

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

Performance Measures

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

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

Performance Measure:

Number and Percent of member services delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan. Numerator: Number of member services delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan. Denominator: All Member services reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other	Annually	Stratified

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

Data Aggregation and Analysis:

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

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

Number and Percentage of members with appropriately completed and signed service plans indicating choice of waiver services and providers. Numerator: Number of members with appropriately completed and signed service plans indicating choice of waiver services and providers. Denominator: Number of members reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

WMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 5px;">95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

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

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

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

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

Remediation for Service Plan Assurances:

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

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

If any instances are found through provider audit in which a member's service plan failed to address the member's assessed needs or failed to support the member's personal goals either by the provision of waiver services or other means, or if a member's service plan was not revised when warranted by changes in the member's needs, or a member's services were not provided in the type, scope, amount, duration and frequency as specified in the plan, the OHS MSU Programs Assistant Administrator for Quality Assurance/Improvement provides to the Provider a final audit report that includes information regarding these deficiencies that require a corrective action plan. The agency is given 30 calendar days to submit the corrective action plan which must address all deficiencies and must include immediate resolution with time-frames for completion of correction of deficiencies for plans that are still active and for which correction is reasonably feasible. Providers operating under corrective action plans are required to submit monthly Progress Reports for 2 months to the MSU Quality Assurance/Improvement department. At the conclusion of a corrective action cycle, the MSU Provider Audit team performs a follow up audit of the Provider.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 548 794 631" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 862 1339 945" type="text"/>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

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

Consumer-Directed Personal Assistance Services and Supports (CD-PASS). CD-PASS consists of Personal Services Assistance, Advanced Personal Services Assistance, Optional Expense Account for allowable goods and services, and administrative Financial Management Services. These services enable individuals in need of assistance to carry out functions of daily living, self-care, and mobility in their own homes and in the communities of their choosing.

Member as Employer

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

This means the member:

- Is the Common Law Employer-of-record as defined by the Internal Revenue Service (IRS);
- Recruits, hires and, as necessary, discharges the PSA/APSA;
- Provides instruction and training to the PSA/APSA on tasks to be done;
- Determines where and how the PSA/APSA works;
- Develops the weekly work schedules; Defines what is to be accomplished in accordance with the service plan;
- Within Individual Budget Allocation limits, determines hourly wages to be paid for the work within a range allowing for meaningful discretion of the Member;
- Supervises employee work time and electronically approves all hours paid through the EVV system (with the possible exception of a live-in caregiver); and
- Provides tools and materials for work to be accomplished.

The member may designate their adult (18 or over) spouse, family member or friend as an authorized representative to assist in executing these Employer functions. The authorized representative may not be member's PSA or APSA.

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

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

CD-PASS members are responsible for training their PSAs/APSAs, although, when deemed necessary ADvantage Nursing services may be authorized to provide assistance with training.

The IRS Fiscal Agent for the CD-PASS service option contracts with OHS through a Request for Proposal (RFP) process. The fiscal agent will perform financial management, payroll services, and time and attendance for members and their workers. The Fiscal Agent is responsible for training both the CD- PASS member and their PSAs/APSAs workers on use and utilization of the Electronic Visit Verification (EVV) process and procedure.

The Individualized Budget Allocation (IBA)

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

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

The IBA defines the level of financial resources required to meet the member's need for CD-PASS services. If the member's service needs change due to a change in health and/or a change in the level of available supports, the CDA/CM amends CD-PASS service units to a level appropriate to meet member needs and submits to the MSU for review and authorization.

CD-PASS members are required to have emergency back-up plans in the event a provider of services and supports essential to the individual's health and welfare is not available. Any of the following may be used in planning for the backup:

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

In addition, the following system backups will be available to each CD-PASS member:

- Case Management providers are required to provide members with 24 hour/7 day a week, toll-free access to Case Management resources to arrange intervention assistance in response to a health or safety emergency;
- If the member meets eligibility criteria, a Personal Emergency Response System (PERS) may be authorized as an additional backup alert for emergency assistance;

The MSU may expeditiously authorize and facilitate access to ADvantage Adult Day Care, Nursing Facility Respite and/or Agency Personal Care services for backup support to the member in emergency circumstances.

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

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

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

CD-PASS Service Eligibility and Member Choice

The CD-PASS service is an option for ADvantage members who meet the following criteria:

- Have an existing need for CD-PASS services to prevent institutionalization; and
- Assurance of member health and safety with CD-PASS services can reasonably be made based on a review of service history records.

Within CD-PASS, as contrasted with Agency provided service delivery, the member's health and safety is more dependent upon the member's capacity and willingness to assume an active role in: service planning; provider recruitment; training, management and supervision of the care attendant; CD-PASS service budgeting and fiscal management; and monitoring and managing health and preparation for emergency backup. The MSU reviews the UCAT and service history records to evaluate member capacity and willingness to assume responsibility. The ADvantage Program provides support to the CD-PASS participant in each area in which the review indicates member will require assistance to assume responsibility of required responsibilities. For example, an ADvantage CDA/CM assists with service, ongoing monitoring and emergency backup planning; the FMS assists, as needed, to prepare, equip and assist the member in their employer role to recruit, train, manage and supervise PSA and APSA providers and to assist with CD -PASS services budgeting and fiscal management; and an ADvantage skilled nurse may, as needed, assist in training the PSA or APSA provider on caregiving tasks. However, in each area, the role of the provider is to assist, not assume the responsibility.

Based upon review of service history records, any of the following would be basis to deny a request for CD - PASS due to inability to assure member health and safety:

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

If the member chooses not to direct their services or does not meet participation criteria, including the required use of EVV, Agency Personal Care and/or other ADvantage services of the member's choice are arranged to meet the needs of the member.

FMS services are compensated as part of bundled service funds for waiver administrative responsibilities. The private entity that serves as the IRS Fiscal Agent and EVV vendor is paid a flat monthly rate for each member per competitive contract bid award.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

The MSU will provide information on the CD-PASS service option to all new ADvantage members. Whenever a new member is referred to the MSU for ADvantage enrollment and service plan development, the MSU sends a CD-PASS service option brochure to the member's mailing address or personal email.

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

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

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

The member must make a voluntary informed choice to participate in the CD-PASS service option. To support the decision-making process, the MSU will make available to the member, and as applicable their designated "authorized representative" or "legal representative", a self-guided orientation to CD-PASS including the member's role as employer and the role of each of the other participants in this unique service delivery option.

As part of the informed decision-making process for CD-PASS, the MSU will provide consultation and assistance during enrollment. The orientation and enrollment process will provide the member with a basic understanding of what is expected of them as a CD-PASS service recipient, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

MSU will make available to the Member an Employer and Employee Handbook covering roles and responsibilities; explaining the enrollment packets and service planning process; scheduling; service rules and limitations; and prevention of abuse, neglect, and exploitation.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

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

Waiver services may be directed by a legal representative of the participant.

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

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

The member may designate an “authorized representative” to assist them with their employer responsibilities. The designated “authorized representative” may counsel and advise the member regarding any and all CD-PASS activities and take actions as directed by the member, but may not make decisions for which the member is responsible. An “authorized representative” cannot sign documents on behalf of a Member. If the member chooses to designate an “authorized representative”, the designation identifying the “willing adult” to assume this role and responsibility is documented with dated signatures of the member, the designee and the member’s Case Manager.

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

The CDA/CM monitors service delivery and the performance of the member’s designated “authorized representative” or “legal representative” to function in the best interest of the member.

The specially trained Consumer Directed Agent/Case Manager (CDA/CM) monitors the CD-PASS Member’s well-being, the quality of CD-PASS supports and services, and the Member’s satisfaction with services, monthly. As a part of the initial and annual reassessment service planning process, the need for an “authorized representative”/non-legal representative is assessed by the Interdisciplinary Team (including the member and the CDA/CM) to function in the best interest of the member. The designation of an Authorized Representative and the legal status of the member is reviewed annually by the Case Manager and submitted to the MSU at the annual service plan reassessment. If the member chooses to designate an “authorized representative”, the designation identifying the “willing adult” to assume this role and responsibility is documented with dated signatures of the member, the designee and the Member’s Case Manager. The authorized representative may not be Member’s PSA or APSA and is not financially reimbursed for their services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

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

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 Medicaid Services Unit contracts with an administrative Financial Management Services (FMS) vendor for members who choose to self-direct their services through the ADvantage CD-PASS service option. The private entity that serves as FMS is selected as a result of a competitive bid following procedures outlined in the Oklahoma Central Purchasing Act. FMS services may include EVV services to comply with Federal Rules and Regulations.

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

FMS services are compensated as part of bundled service funds for waiver administrative responsibilities. The private entity that serves as the IRS Fiscal Agent and EVV vendor is paid a flat monthly rate for each member per competitive contract bid award.

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

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

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Financial Management Services may include assistance with employer responsibilities. In addition, FMS provides to the member, in the form of training materials, verbal and/or written instruction, and training events, orientation and instruction regarding employer responsibilities as well as employer information and management guidelines, material, tools and staff consultant expertise to support and assist the member to successfully perform Employer-related functions.

In addition, Financial Management Services include responsibility for assisting the member in obtaining criminal and abuse registry background checks, on behalf of the member, for prospective hires for PSAs or APSAs and for performing Internal Revenue Services (IRS) fiscal reporting agent and other financial management tasks and functions including employer payroll and associated mandatory withholding for taxes performed on behalf of the member as employer of the PSA or APSA. In addition, FMS provides an integrated EVV time and attendance solution that meet members' needs.

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

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

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

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.

OHS reviews monthly reports that track and summarize the performance of FMS contracted entity in meeting contract performance standards for CD-PASS member customer support. In addition, OHS and OHCA staffs participate in monthly teleconference calls with FMS contracted entity to review management reports and review issues related to contracted responsibilities. On an ongoing basis, OHS MSU staff review individual and aggregated reports that track CD-PASS member budget disbursements and meet as needed with the FMS contracted entity to address specific issues with Members or service operation. OHS and OHCA regularly review FMS contracted entity performance during quarterly Quality Strategy Council or during LTSS Council meetings.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Case Management Activity. Information and assistance in support of participant direction are furnished as an

element of Medicaid case management services.

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

CD-PASS Planning and Supports Coordination

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

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

Principles of Person-Centered Planning are as follows:

- The person is the center of all planning activities.
- The member and their representative or support team are given the requisite information to assume a controlling role in the development, implementation and management of the member's services.
- The individual and those who know and care about him or her are the fundamental sources of information and decision-making.
- The individual directs and manages a planning process that identifies his or her strengths, capacities, preferences, desires, goals and support needs.
- Person-centered planning results in personally-defined outcomes.

The CDA/CM will provide support to the member in this person- centered planning process, including providing information about qualified providers of ADvantage services and information on community resources for informal and non-ADvantage formal services of interest to the member. The CDA/CM is responsible for submitting the developed plan to the MSU for approval. ADvantage requirements for Service plan monitoring and review for CD-PASS member plans are the same as for other ADvantage service plans.

In the planning process, the CDA/CM helps the member define support needs, service goals and service preferences including access to and use of generic community resources.

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

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

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

Waiver Service Coverage.

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

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response Systems	
Specialized Medical Equipment and Supplies	
Home-Delivered Meals	
Nursing	
Assisted Living Services	
Environmental Accessibility Modifications	
Prescribed Drugs	
Institution Transition Services	
Hospice Care	
Consumer-Directed Personal Assistance Supports and Services	
Personal Care	
Extended State Plan Skilled Nursing	
Advanced Supportive/Restorative Assistance	
Therapy Services	
Adult Day Health	
Case Management	
Respite	

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:

Financial Management Services may include providing information and assistance with employer responsibilities. This information and assistance may be provided by OHS or by the contracted fiscal agent. The FMS provides to the member, in the form of training materials, verbal and/or written instruction, and training events, orientation and instruction regarding employer responsibilities, including EVV, as well as employer information and management guidelines, material, tools and staff consultant expertise to support and assist the member to successfully perform Employer-related functions. An Employer orientation packet is provided to each CD-PASS participant upon enrollment.

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

OHS reviews monthly reports that track and summarize the performance of the FMS contracted entity in meeting performance standards for CD-PASS member support. In addition, OHS and OHCA staff participate in monthly teleconference calls with the FMS contracted entity to review management reports and review issues related to contracted responsibilities. On an ongoing basis, OHS MSU staff review individual and aggregated reports that track CD-PASS member budget disbursements and meet as needed with the FMS contracted entity to address specific issues with Members or service operation. OHS and OHCA regularly review the FMS contracted entity performance during quarterly Quality Management Strategy Council or during LTSS Council meetings.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

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

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

As a part of the service planning process, the need for an “authorized representative”/independent advocate is assessed by the Interdisciplinary Team (including the member and the CDA/CM) to function in the best interest of the member. The designation of an Authorized Representative and the legal status of the member is reviewed annually by the Case Manager and submitted to the MSU at the annual service plan reassessment.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily

terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

ADvantage members may voluntarily terminate any services at any time including CD-PASS services. If a member voluntarily request termination of participation in CD-PASS, the CDA/CM works with the member to develop agency services of the member’s choice to replace CD-PASS services to meet member needs. Existing PSA and/or ASPA services continue as authorized, or the member’s backup plan of choice is implemented, until agency replacement services start.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of member directed services may occur if it is determined through documentation that the individual can no longer effectively self-direct their services due to:

- Participant abuse or exploitation of their employee;
- Participant falsification of an EVV time-sheet or other work record;
- Participant is unable to operate within their IBA even with FMS assistance;
- Participant is unable to follow the employer guidelines and/or processes established by OHS; or,
- Participant UCAT documents that the member is “high risk” and would need assistance in performing employer responsibilities and the member is unable or unwilling to obtain an Authorized Representative to assist.

If termination of member self-direction occurs, the CDA/CM works to ensure continuity of service and member health and welfare during the transition period. The CDA/CM assists the individual to replace CD-PASS services with comparable services from one or more qualified provider agencies selected by the member.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		1473
Year 2		1502
Year 3		1532
Year 4		1563
Year 5		1594

Appendix E: Participant Direction of Services

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

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

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

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

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

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

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

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

Specify how the costs of such investigations are compensated:

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

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to state limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Individualized Budget Allocation (IBA)

The member and authorized/legal representative (if any), along with his or her CDA/CM, develops the service plan that includes a budget for the services that are self-directed. The member's assessed needs determine the intensity, frequency and duration of services developed within the service plan.

For CD-PASS services, the IBA sets the overriding cost constraint at the individual member level. The IBA is the annualized budget amount calculated to cover reimbursement for CD-PASS services of Personal Services Assistance, Advanced Personal Services Assistance and allowable goods or services necessary to support Member/Employer in carrying out Employer responsibilities or for delivery of authorized CD-PASS services.

The CDA/CM completes the service plan and the budget. The MSU reviews the budget and service plan to assure compliance with cost methodology within the waiver program. When the service plan is approved, the information is transmitted to the FMS provider to establish a budget account for each self-directed member and their services.

The calculation tool and description of the Individualized Budget Allocation (IBA) Expenditures Accounts Determination process are on file with OHCA. In addition, the description of the IBA Expenditure Accounts Determination process is described in Oklahoma Administrative Code (OAC317:30-5-764) which is maintained by the Office of Administrative Rules within the Office of Secretary of State and posted on the Secretary of State website.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The CDA/CM works with the member to determine the CD-PASS individual services needed, the budgeted amounts for each service and the total CD-PASS IBA. The CDA/CM confirms that the member understands the established CD-PASS budget amounts included in the service plan and obtains the member's agreement to the service plan. The member may request an adjustment in the services and budget amount at any time through the CDA/CM.

The following is the notice of the right to request a fair hearing provided to the member:

"I have been informed of my right to request a fair hearing if I disagree with any action taken regarding my Medicaid services. A fair hearing is intended to safeguard my rights and interests by affording me due process. I understand I have the right to appeal any action of the Oklahoma Human Services which I consider improper by reporting my complaint verbally or in writing to a local county office."

In addition, at any time a negative action occurs or a member perceived negative action occurs, the CM informs the member of their right to a fair hearing and may assist the member to obtain the appropriate forms, phone contacts etc. to make the request.

For a participant's CD-PASS budget amount to be reduced, the CDA/CM would amend the service plan line to reflect the reduction. The member would be afforded the opportunity to review the amended service plan and indicate whether they agreed with the change or not. In addition, the CM informs the member of their right to a fair hearing if the member disagrees with the change.

The CDA/CM submits the CD-PASS budget with the service plan to MSU for approval. The FMS provider communicates the confirmed budget allocation after the service plan has been approved. The FMS provides a copy of the approved budget to the member. Each month the FMS provides the member detailed information of expenditures for the previous month and overall budget status.

The IBA calculation and total is reviewed by the MSU during the CD-PASS service eligibility determination process and service plan authorization process. In addition, based upon the member record, UCAT review and other available information, the MSU provides FMS support to cover the CD-PASS member's Employer Support needs.

The IBA defines the resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The MSU, upon favorable review, authorizes the amended plan. The member, with assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often if necessary.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

--

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Monthly, the FMS contractor produces an individualized IBA status report for each CD-PASS participant which is mailed to the participant and also available electronically. The monthly status report includes the actual expenditures and monthly balance for each service.

Independently, the CDA/CM monitors the CD-PASS participant monthly regarding adequacy of service delivery and satisfaction with services. The CDA/CM monitoring includes review with the member of status report expenditure variance and assistance to the member in making any needed adjustments to stay within the budget allocation.

MSU reviews utilization monthly based on hours authorized per week, provides controls to assist members to not exceed authorized hours, and notifies Members that are exceeding those authorizations in the event controls fail. Members are advised of their authorized amount and informed of their responsibilities to remain within these amounts. FMS and CDA/CM assistance is available to all Members in need of counseling and guidance. If a Member refuses or is unable to supervise service utilization, the Member's case will be reviewed by the Ethics of Care Committee (EOCC) and the Member may be returned to agency care through an EOCC determination.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Fair Hearings regarding eligibility are heard by OHCA. The OHS nurse reviews the Freedom of Choice form with all ADvantage applicants informing them of their right to a fair hearing. A copy of fair hearing rights is provided to each applicant. Service appeals are heard by OHCA. If a participant or applicant believes he or she was not given a choice of home and community-based services as an alternative to institutional care, denied the services of their choice or the provider of their choice, or whose services are denied, suspended, reduced or terminated, the individual may request a hearing through the OHCA Legal Division. At the hearing, the individual will have the opportunity to express his or her concerns to the hearing officer. The individual may be represented by counsel if they desire. This is described in OAC 317:2-1-2.

During the assessment visit to establish medical eligibility, the OHS nurse explains to the member (and/or his/her legal representative) his/her rights to a Fair Hearing as well as how the member may request a Fair Hearing.

In addition, as part of the application process, the applicant is notified by the OHS staff 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 OHS 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 OHS in completing this application or in obtaining required verification
- reapply at any time benefits stop
- receive information about programs administered by OHS

The member is informed by the OHS 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 Oklahoma Health Care Authority, c/o Grievance Docket Clerk P.O. Drawer 18497, Oklahoma City, OK 73154-0497. The applicant is advised of the time frame in which an appeal must be filed and 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
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 the ADvantage waiver have many needs that affect their medical services while being served in the community. Moreover, the agency recognizes that an additional dispute resolution process would be helpful for persons who desire additional medical service beyond those authorized by the agency.

Therefore, the agency will offer dispute resolution in addition to the fair hearing process; however, the member is informed that making use of the dispute resolution process is not a pre-requisite or substitute for the fair hearing process. Additional dispute resolution is available for both eligibility and medical services dispute issues. Dispute resolution must be concluded within 45 days of the request by the member. The process begins with an application for additional dispute resolution. Additional dispute resolution will be conducted between the member, legal services and OHCA care management unit. It may involve a meeting with the member in their home. No admission against interest made in the additional dispute resolution process may be utilized as evidence by parties at the fair hearing.

The additional dispute resolution process will attempt to include other state agencies as well as other social services to the extent they can help the member with their medical needs. Additionally, the additional dispute resolution process will be used to resolve disputes regarding medical care.

If dispute resolution does not resolve the member's dispute, the fair hearing process will continue.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

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

Oklahoma Human Services (OHS)

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).

OHS manages a statewide complaint/concern discovery and remediation system for the Medicaid Services Unit (MSU) CareLine that offers timely response to grievances/complaints. Through a toll-free 1-800 telephone number, the Resource Center provides a centralized avenue for complaints, inquiries, or health and safety issues from members, friends, family, state agencies, providers, and the community at large. The Resource Center is designed to help safeguard the health and safety of members served through the ADvantage Program. The Resource Center receives all initial Member phone inquiries, resolves routine issues, and forwards the complex or critical issues to the Escalated Issues team for research and resolution. Each complex or critical complaint call is assigned to the Escalated Issues team to research the issue and work collaboratively with all parties as needed to facilitate resolution of the issue. As part of their orientation to the ADvantage Program, members are instructed to call the 1-800 telephone number with complaints, concerns, or requests for information. The member is informed that filing a grievance or making a complaint through the Resource Center is not a pre-requisite or substitute for a Fair Hearing – that the member retains, at all times, the right to request a fair hearing. However, by utilizing the 800 telephone number, resolution may be achieved without need for a fair hearing. The Resource Center utilizes a system to categorize/subcategorize complaints and identifies areas in the system for potential quality improvement activities. Escalated Issues team follows established timelines for prompt resolution depending on the category/subcategory of the issue. The Escalated Issues staff follows up on all issues until resolution is achieved. The major types of grievances/complaints that are resolved may be categorized as follows:

Category - Health and Safety

Subcategory - Abuse, Neglect or Exploitation

Description/ Response Timeline - Allegation of a possible abuse, neglect, self-neglect, or exploitation issue – within 1 working day acknowledgment and/or response by OHS staff.

Mechanisms used to resolve inquiry/complaint: Allegation reported to Adult Protective Services and to Provider Agency, as appropriate.

Category - Health and Safety

Subcategory - Escalated Service Delivery Issues

Description/ Response Timeline - When any issue appears to have immediate impact upon the health or safety of the Member and requires an immediate response – within 1 working day acknowledgment and response by OHS staff.

Mechanisms used to resolve inquiry/complaint: OHS staff coordinates with responsible provider agency for resolution.

Category - Service Delivery

Subcategory - Not Receiving Services

[Note: Any service delivery issue that appears to have impact on Member's Health or Safety will also follow the escalated service delivery process.]

Description/ Response Timeline - Current, existing Member not receiving ADvantage services listed on the service plan – within 3 working days acknowledgment and/or response by OHS staff.

Mechanisms used to resolve inquiry/complaint: OHS staff coordinates with responsible provider agency for resolution.

Category - Service Delivery

Subcategory - Environmental Modifications

Description/ Response Timeline - Provider / Member is requesting changes or addressing issues that require modifications to the Member's living environment plan- within 3 working days acknowledgment and/or response by OHS staff.

Mechanisms used to resolve inquiry/complaint: OHS staff follow-up to assist Member and coordinates with responsible provider agency for resolution.

Category - Service Delivery Subcategory - Medication Delivery

Description/ Response Timeline - Member is not receiving some or all of the authorized medications available on the ADvantage program plan – within 3 working days acknowledgment and/or response by OHS staff.

Mechanisms used to resolve inquiry/complaint: OHS staff coordinates with responsible provider agency to work with pharmacy or RX help line. Police reports completed when meds stolen, etc.

Category - Service Delivery

Subcategory - Request for Additional Services

Description/ Response Timeline - Member is requesting services that are not on current authorized service plan – within 3 working days acknowledgment and/or response by OHS staff.

Mechanisms used to resolve inquiry/complaint: OHS staff coordinates with responsible provider agency for resolution.

Category - Service Delivery
 Subcategory - New Member Without Initial Service Plan
 Description/ Response Timeline - The Member has been approved for ADvantage services, but service plan has not been implemented – within 5 working days acknowledgment and/or response by OHS staff.
 Mechanisms used to resolve inquiry/complaint: OHS staff validates that member is eligible and works with provider to achieve timely implementation of service plan.

Category - Service Delivery
 Subcategory - Dissatisfaction with Services
 Description/ Response Timeline - The Member is dissatisfied with the delivery of services authorized on their ADvantage service plan – within 5 working days acknowledgment and/or response by OHS staff.
 Mechanisms used to resolve inquiry/complaint: OHS staff validates that service is an ADvantage authorized service and coordinates with provider agency for resolution.

Category - Service Delivery Subcategory - Move
 Description/ Response Timeline - Member has moved and needs services at new residence–within 3 working days upon being notified that the Member has moved, OHS staff will update the member’s address in the system and notify the assigned Case Manager of the need for services to be transfers.
 Mechanisms used to resolve inquiry/complaint: Case Manager validates that member’s provider agency remains on referral for the new address and coordinates with current or new provider for start of services at new address.

Category - Service Delivery Subcategory - Transfer Request
 Description/ Response Timeline – Member requests transfer to another provider agency and does not want any further contact with Case Management Provider – within 5 working days acknowledgment and response by OHS staff.
 Mechanisms used to resolve inquiry/complaint: OHS staff coordinates with provider agency to facilitate transfer to Member’s new choice of provider or works with other OHS staff to complete an administrative transfer of providers for the Member.

The Resource Center and the Escalated Issues team’s database provide information on member health and welfare issues and possible service delivery system gaps or inadequacies. If data identifies trends or a network provider specific issue, a morbidity and mortality review and root cause analysis may be conducted. If system issues are identified, corrective If system issues are identified, corrective action is initiated immediately. The Resource Center and the Escalated Issues teams system tracks the status and categories/subcategories of complaints and identifies areas in the system for potential quality improvement activities.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines

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

The ADvantage Program requires any serious incident that harms or potentially harms a member's health, safety or well-being to be immediately identified, reported, reviewed, investigated and appropriately addressed. This policy will not supersede any federal, state or regulatory body statutes, laws or regulations. The Critical Incident Reporting and Tracking System addresses all member incidents listed and defined by the policy. As required by state law, responsible parties must report abuse, neglect and/or exploitation. Adult Protective Services (APS) is the designated State Agency lead with investigative authority in the event of critical incidents involving abuse, neglect or exploitation. Discovery of member abuse, neglect and/or exploitation are to be reported immediately to APS. In addition, the provider that first identifies a critical incident is required to report the incident to the MSU on the appropriate form within one business day. The following critical incidents must be reported to the MSU: sexual abuse, physical abuse, neglect, exploitation, (any of these four must be reported to APS which is the lead investigative authority for these incidents), medication error requiring medical attention, fall or injuries requiring medical attention, loss of residence due to disaster, suicide attempt, questionable (unexpected) death, interruption of critical medical equipment supports, member lost or missing, and/or use of restraints. The member's case manager, with the support of the MSU Escalated Issues team, facilitates the evaluation and/or investigation process of the critical incident.

Adult Protective Services (APS) is a program within Oklahoma Human Services (OHS) authorized in Title 43A of the State of Oklahoma statutes, sections 10-101 through 10- 111. The state has adopted the definitions of abuse, neglect and exploitation outlined in the State of Oklahoma statute (O.S. 43A § 10-103. Definitions):

"Abuse" means causing or permitting:

- a. the infliction of physical pain, injury, sexual abuse, sexual exploitation, unreasonable restraint or confinement, mental anguish or personal degradation, or
- b. the deprivation of nutrition, clothing, shelter, health care, or other care or services without which serious physical or mental injury is likely to occur to a vulnerable adult by a caretaker or other person providing services to a vulnerable adult.

(O.S. 43A § 10-103. A.8)

"Financial neglect" means repeated instances by a caretaker, or other person, who has assumed the role of financial management, of failure to use the resources available to restore or maintain the health and physical well-being of a vulnerable adult, including, but not limited to:

- a. squandering or negligently mismanaging the money, property, or accounts of a vulnerable adult,
- b. refusing to pay for necessities or utilities in a timely manner, or
- c. providing substandard care to a vulnerable adult despite the availability of adequate financial resources.

(O.S. 43A § 10- 103. A.10)

"Neglect" means:

- a. the failure to provide protection for a vulnerable adult who is unable to protect his or her own interest,
- b. the failure to provide a vulnerable adult with adequate shelter, nutrition, health care, or clothing, or
- c. negligent acts or omissions that result in harm or the unreasonable risk of harm to a vulnerable adult through the action, inaction, or lack of supervision by a caretaker providing direct services.

(O.S. 43A § 10-103. A.11).

Other definitions listed in the statutes include: self-neglect, verbal abuse, sexual exploitation, sexual abuse, indecent exposure, personal degradation, exploitation.

In accordance with the State of Oklahoma statute (O.S. 43A § 10-104.A), any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation shall make a report as soon as the person is aware of the situation to:

1. Oklahoma Human Services; or
2. The municipal police department or sheriff's office in the county in which the suspected abuse, neglect, or exploitation occurred.

In addition, the State of Oklahoma statute (O.S. 43A § 10-104.B) states that,

Persons required to make reports pursuant to this section shall include, but not be limited to:

1. Physicians;
2. Operators of emergency response vehicles and other medical professionals;

3. Social workers and mental health professionals;
4. Law enforcement officials;
5. Staff of domestic violence programs;
6. Long-term care facility personnel, including staff of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICFs/IID), assisted living facilities, and residential care facilities;
7. Other health care professionals;
8. Persons entering into transactions with a caretaker or other person who has assumed the role of financial management for a vulnerable adult;
9. Staff of residential care facilities, group homes, or employment settings for individuals with intellectual disabilities;
10. Job coaches, community service workers, and personal care assistants; and
11. Municipal employees;
12. Financial institutions and CPAs.

The certified ADvantage Provider is responsible for completing their own internal investigation of all critical incidents, unless they have been directed not to do so from an authorized government entity. All Provider investigative reports are submitted to the MSU within 10 working days after the initial Critical Incident Report is completed. When a provider becomes aware of a critical incident, the provider must inform the MSU Escalated Issues team within one working day. The Provider coordinates their critical incident investigation and response efforts with governmental investigative authorities as required by State or Federal law. The Provider uses the following criteria in determining whether a response is adequate for resolution of the critical incident:

- An adequate description of the incident has been obtained
- Documentation reflects the assessment of the illness or injury and its impact to the Participant's health and welfare
- Documentation reflects that appropriate action has been taken to assure the member's continued health and welfare
- Documented history of similar events for previous incidents in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a member has a seizure disorder and a plan has already been developed of how to manage a resultant fall)

The MSU Escalated Issues team reviews all critical incident reports and determines whether the appropriate response to each incidence occurred. The MSU coordinates their investigation and response efforts with governmental investigative authorities as required by State or Federal law. The MSU uses the following criteria in determining whether a response is adequate for resolution of the critical incident:

- An adequate description of the incident has been obtained
- Documentation reflects the assessment of the illness or injury and its impact to the Participant's health and welfare
- Documentation reflects that appropriate action has been taken to assure the member's continued health and welfare
- Documented history of similar events for previous incidents in the past six months (unless there is a documented plan indicating an agreed upon procedure that has been followed, i.e. a members has a seizure disorder and a plan has already been developed of how to manage a resultant fall)

In the ADvantage Program Conditions of Provider Participation (COPP), Case Management, Home Care, Assisted Living, Hospice and Adult Day Health providers are required, as part of their Medicaid contract, to ensure that necessary safeguards have been taken to assure the health and safety of the member. Requirements specify that the provider will follow APS process for reporting potential instances of suspected abuse, neglect and exploitation.

Furthermore, the OHS Medicaid Services Unit (MSU) for the ADvantage Program operates a toll free telephone number (1-800-435-4711) for inquiries or complaints from members, providers, or others. MSU staff report any suspected incidence of abuse, neglect or exploitation to APS.

The Oklahoma Human Services website for Adult Protective Services offers the following guidance on reporting potential abuse, neglect and exploitation. The best way to make a report Oklahoma Human Services is to contact the Abuse and Neglect Hotline or enter a referral through the online reporting portal: abuseisnotok.org or okhotline.org.

The website provides a mailing address, phone number, e-mail address and public portal for reporting potential abuse, neglect and/or exploitation

According to State of Oklahoma statute (O.S. 43A § 10-104 C.1.),

If the report is not made in writing in the first instance, as soon as possible after it is initially made by telephone or

otherwise, the report shall be reduced to writing by Oklahoma Human Services, in accordance with rules promulgated by the Director of Human Services, or the local municipal police or sheriff's department whichever entity received the initial report. The report shall contain the following information:

- a. the name and address of the vulnerable adult,
- b. the name and address of the caretaker, guardian, or person having power of attorney over the vulnerable adult's resources if any,
- c. a description of the current location of the vulnerable adult,
- d. a description of the current condition of the vulnerable adult, and
- e. a description of the situation which may constitute abuse, neglect or exploitation of the vulnerable adult.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

As part of the ADvantage Program Conditions of Provider Participation (COPP), each Case Management, Home Care, Assisted Living, Hospice and Adult Day Health provider must comply with Member Assurances in the delivery of services. At each new member's orientation to the ADvantage Program, the member's chosen case manager provides in-home orientation and education along with written materials to the member and his/her selected support systems regarding member rights and responsibilities, the grievance process and procedures, the case management's emergency phone numbers, the MSU CareLine 1-800 telephone number, health and safety procedures, and recognizing abuse, neglect and exploitation and the process for reporting any incidents of such. ADvantage Program case managers are responsible for ongoing monitoring the health and welfare of members and providing the necessary education and intervention related to abuse, neglect and exploitation of members.

Case Managers provide prevention and education to Members and their caregivers related to abuse, neglect, and exploitation annually at the Member's yearly reassessment and addressed in Case Manager's monthly monitoring contacts with the Member. All ADvantage Members' new and reassessment Service Plan goals submitted to MSU must reflect that the Case Manager has provided, and will continue to provide, ongoing education to the Member, and/or their caregiver(s) regarding how to prevent, identify, and report abuse, neglect, and exploitation. The goal must specifically reflect education and prevention is recurring at minimum monthly during and addressed during the monthly monitoring encounter.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The MSU Escalated Issues team reviews reports of critical events or incidents including suspected abuse, neglect or exploitation. When instances of potential abuse, neglect and exploitation are identified, these instances are immediately reported to Adult Protective Services unless the report was made initially by the provider/reporter. In this case, MSU staff will validate the report was made and received by APS.

Adult Protective Services (APS) is a program within the Oklahoma Human Services (OHS) authorized in Title 43A of the State of Oklahoma statutes, sections 10-101 through 10-111.

In accordance with the State of Oklahoma statute (O.S. 43A § 10-104.A), “any person who has reasonable cause to believe a vulnerable adult is suffering from abuse, neglect or exploitation shall report the situation to authorities as soon as the person is aware of the situation. Reports can be made to the Human Services APS program, the local district attorney’s 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. 43A § 10-104.B) states that, “although the reporting requirement applies to everyone, certain professionals are specifically required by law to report situations.” These include, but are not limited to, social workers, mental health professionals, and other medical professionals.

The Oklahoma Human Services contact information for Adult Protective Services is abuseisnotok.org or okhotline.org, or 1- 800-522-3511.

The website (abuseisnotok.org | okhotline.org) is an online reporting portal where potential abuse, neglect and/or exploitation can be reported. According to State of Oklahoma statute (O.S. 43A 10-104 A) Any person having reasonable cause to believe that a vulnerable adult is suffering from abuse, neglect, or exploitation shall make a report as soon as the person is aware of the situation.

APS investigations must be initiated with a visit to the alleged victim within 5 working days of receipt of referral, or within 24 hours of receipt of referral for emergency situations. Substantiated investigations are to be completed, including all documentation with a report of findings, within 60 days to the District Attorney. In addition a copy of the APS report is sent, as appropriate, to the Oklahoma Health, to the regulatory or licensing board, to the OHS Office of Client Advocacy and/or to the court of guardianship, if alleged victim has a legal guardian. Notification of investigative findings is reported at the same time to the alleged victim, next of kin, caretaker and guardian.

For reported incidents other than abuse neglect or exploitation, the MSU Escalated Issues team evaluates reports and results of investigations which are communicated to the member and legal guardian, or next of kin, in no more than five working days. The MSU Escalated Issues team works with the member, member’s family, provider and/or others to verify that appropriate actions are taken to prevent future incidents and assure the Member’s continued health and welfare.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Oklahoma Human Services (OHS) Adult Protective Services (APS) is the designated agency for overseeing instances of potential abuse, neglect and exploitation. In accordance with Title 43a Section 10-104, if staff of the Oklahoma Human Services Aging services division, and other OHS staff that work with ADvantage members, have reasonable cause to believe that a vulnerable adult is a victim of abuse (including verbal abuse), neglect (including self-neglect and financial neglect), or exploitation, a report is made to the Department's Adult Protective Services (APS). This is done through the statewide abuse hotline (1-800-522-3511), through the OHS web links of abuseisnotok.org or okhotline.org and through contact with APS staff in the local offices.

In instances of substantiated abuse, neglect, or exploitation (a/n/e) by paid caregivers a referral is sent to OHS Adult Protective Services for screening, then forwarded to the Office of Client Advocacy (OCA) for further investigation. OHS. Results, including progression to the caregiver being placed on the Department's Community Services Worker Abuse Registry, are communicated to OHS and the Provider Agency that employs the paid caregiver.

During provider audits, the OHS Quality Assurance/Improvement staff collects data and forwards a report to Adult Protective Services of all instances of suspected A/N/E that are noted during the audit. If it appears that the member is in a situation of immediate danger, a report is made immediately.

In addition, to information and findings of suspected A/N/E shared with APS, the ADvantage Administration has developed an internal system for prevention and identification of instances of potential a/n/e or concerns for the health and safety of ADvantage Program members. The MSU has in place the following mechanisms to safeguard ADvantage Program members.

Service Plan Authorization: Each member's service plan and service plan addenda are reviewed by MSU staff prior to authorization. The staff review every member's service plan and other required documentation. Any reference to involvement of APS or any other concern regarding the member's health and safety requires involvement of the member's case manager for follow up, clarification or additional information prior to authorization of the service plan.

Resource Center and the Escalated Issues team: Reports of or concern about a member's health and welfare are referred to or received by the Resource Center and/or the Escalated Issues team. Any person can call the 1-800 number including - members, family members, providers, state agencies, or any other individual. The Resource Center system provides a centralized avenue for responding to inquiries, concerns, and complaints. In the case of suspected abuse, neglect or exploitation, such reports are handled with a sense of urgency and must be escalated to the appropriate Escalated Issues team supervisory staff for immediate assignment to Escalated Issues team for verification of APS notification and to provide additional information as necessary.

Critical Incidents: Providers utilize the Critical Incident report form to report serious issues to the Medicaid Services Unit (MSU). Those incidents that require follow up by the Escalated Issues team are tracked and resolved by the team. Critical Issues are categorized as allegations related to PCA/PSA, exploitation, falls or injuries requiring medical attention, interruption of needed medical supports, loss of residence due to disaster, lost or missing, medication error requiring medical attention, neglect and self-neglect, physical abuse, questionable or unexpected death, suicide attempt or ideation, sexual abuse, or use of restraints. The OHS MSU provides oversight of the reporting of and response to all critical incidents. MSU staff receive provider agency reports of critical incidents and review in accordance with policy. This review of critical incident reports is ongoing.

Provider Question: All ADvantage Program providers may notify Medicaid Services Unit (MSU) of potential abuse, neglect and exploitation via a secure electronic portal within the waiver management information system (WMIS). OHS. This system provides easy access for providers to communicate their inquiries, concerns and complaints. Any instance of potential abuse, neglect or exploitation or concerns for the member's health and safety received in this manner are escalated to the appropriate Escalated Issues team supervisory staff for notifying APS immediately.

Morbidity and Mortality Review (M&M): Mortality Reviews are completed to identify causes of death that may have been preventable and systemic actions that may be taken to prevent similar occurrences from happening in the future. Clinical review by a Registered Nurse of unexpected deaths or serious physical injury may result in a morbidity and mortality review by MSU clinical staff and involve all necessary parties, including provider agencies. The M&M review may result in a Root Cause Analysis (RCA) to determine the primary and secondary causes of such incidents so that individual or system causes can be addressed and corrected.

Conditions of Provider Participation (COPP): These certification documents with ADvantage Program providers specifically address safety, protection, and welfare of members as well as provider requirements for documenting and reporting abuse, neglect and exploitation.

Provider Performance Audits: The MSU Provider Audit team conducts provider performance audits, financial/staff audits, and member satisfaction surveys. Audit criteria involves reviewing the member's file for signs of potential abuse, neglect and exploitation as well as observing for such signs.

ADvantage Program Case Management Training: This comprehensive training includes all ADvantage waiver case management processes, and specifically addresses member orientation, recognition of abuse, neglect and exploitation, and required reporting and monitoring of suspected incidents.

Community Service Worker Registry: According to Oklahoma Administrative Code 340:100-3-30, the Oklahoma Human Services operates a Community Services Registry that allows potential providers and other employers to screen potential employees for offenses involving abuse, neglect and exploitation.

Certified Nurse Aide Registry: The Oklahoma State Health operates a Certified Nurse Aide Registry. According to the OSDH (<https://oklahoma.gov/health.html>), "The Nurse Aide Registry serves unlicensed persons and employers of these persons, who provide nursing or nursing-related services to individuals receiving services in long term care facilities, home health agencies, intermediate care facilities for the cognitive or intellectual disability, residential care facilities, and adult day care centers."

The duties of the nurse aide registry include: (1) review and approve/disapprove nurse aide training program curriculum; (2) review and approve/disapprove nurse aide training programs; (3) review and approve/disapprove nurse aide testing; (4) develop and maintain the nurse aide and non-technical services worker registry (5) maintain the abuse registry; (6) certify nurse aides; (7) provide public education; and (8) develop rules, policies, procedures, applications and forms necessary to implement the program.

The MSU maintains a computer-based systems for storage, retrieval and dissemination of information that supports the ADvantage Program. This system 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. MSU departmental managers review reports for trends and follow policies, procedures and business rules for escalation to the appropriate staff, teams, committees or entities as required. This includes review by the MSU's Ethics of Care Committee (EOCC). The EOCC reviews trends and prioritizes opportunities for improvement.

Some oversight activities are continuous and ongoing while others have set schedules. Web access to the Community Service Worker Registry and the Certified Nurse Aide Registry are ongoing and continuous for both reporting abuse and for accessing information as to notation of abuse, neglect or exploitation by individual workers. The Resource Center/Escalated Issues team and Provider Question offer continuous public access for reporting of abuse, neglect or other health and safety concerns. Mortality and Morbidity (M& M) reviews occur as needed. Case Manager trainings are offered one or more times per month. Service plan reviews and authorizations are annual although review of amendments to add or change a service may occur at any time during the year. Provider Audits and review of COPP occur annually. From each oversight source, information related to abuse, neglect, and exploitation or member health and safety are dealt with first on an individual basis for immediate response; however, information is periodically generated and reported on a provider-specific basis to evaluate whether additional training or intervention with particular providers may be needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses*

regarding seclusion appear in Appendix G-2-c.)

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or seclusion is a reportable incident.

OHS Adult Protective Services (APS) is the designated state agency responsible for investigating any report of unauthorized use of restraints or seclusion as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

Medicaid Services Unit (MSU) has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive critical incident reporting system.

The ADvantage Program ensures any report of use of restraints or seclusion are reported to APS.

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:

OHS Adult Protective Services (APS) is the designated state agency responsible for investigating any report of unauthorized use of restrictive interventions as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

MSU has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive critical incident reporting system.

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or restrictive interventions is a reportable incident.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

OHS Adult Protective Services (APS) is the designated state agency responsible for investigating any report of unauthorized use of restraints or seclusion as a form of abuse in accordance with statutory timeframes for such investigations. As noted in Appendix G-1, the Adult Protective Services program is authorized in Title 43A of the Oklahoma Statutes, Sections 10-101 through 10-111. A report can be made to Adult Protective Services 24 hours a day, 365 days a year.

Medicaid Services Unit (MSU) has a coordinated system of communication with APS regarding abuse, neglect, and exploitation of any member as part of a comprehensive critical incident reporting system.

The ADvantage Program has processes to detect the unauthorized use of restraints or seclusion during the delivery of waiver services. These processes include Case Management regular monitoring of the member's health and welfare, the performance of periodic provider quality reviews including Provider Audits and the incidents reporting system in which restraints or seclusion is a reportable incident.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Only Assisted Living service providers are responsible for medication management. Assisted Living Services providers are responsible for monitoring medication regimens for ADvantage participants residing in Assisted Living (AL). In accordance with licensure standards, the AL provider shall have a registered nurse or pharmacist review participant medication regimens monthly and, in addition, have a consultant pharmacist review the medication regimens quarterly. The consultant pharmacist review comprises a section of the quarterly AL's Quality Assurance Committee report. The pharmacist reviews and investigates medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents and reports findings and recommendations through the Quality Assurance Committee to address potentially harmful practices. For ADvantage participants receiving Assisted Living Services, which includes medication management and medication assistance, the Case Manager monitors receipt of medications monthly, in accordance with the plan of care.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Oklahoma State Department of Health (OSDH), the state entity responsible for licensing ALs, provides follow-up and oversight to ensure participant medications are managed appropriately. The Department conducts unannounced inspections in assisted living centers to determine compliance with state laws and regulations related to medication administration:

OAC 310: 663-19-2 et.al, and OAC 310: 675-9-9.1(c). In addition, rules governing medication staffing found at 310:663-9-2(a) and (b) are ensured through personnel record reviews and interviews with staff. Regulations at OAC 310: 663-19-1(a) requires centers to record medication errors, and, 310: 663-11-1 and 2 requires the center to monitor trends and incidents at least quarterly.

The annual inspection protocol includes "Task 5 – Medication Administration." This protocol is utilized to determine whether the center has adopted written policies and procedures to ensure safe administration of medications to residents. The protocol requires the surveyor to review the center's policies and procedures for safe medication administration, and surveyors directly observe medication administration to determine whether staff adheres to adopted procedures. Surveyors also review incident reports, clinical records and the AL's Quality Assurance Committee Pharmacist findings, recommendations and follow-up evaluations to ensure the center has implemented corrective actions when necessary.

Violations of rules are recorded in the survey report provided to the AL. The center has 10 working days after receipt of the notice of violation to file a plan of correction with the Department (OAC 310: 663-25-4 (b)). Within 60 days of the original visit, a revisit survey is conducted to ensure corrective action has successfully removed the deficient practice.

The OSDH medication monitoring gathers information on potentially harmful practices through the medication monitoring survey tools. In addition, the OSDH surveyors review the monthly reports compiled by the AL consultant pharmacist who documents medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents. The reports contain both findings and recommendations to the AL's Quality Assurance Committee to address potentially harmful practices.

The OSDH reviews medication monitoring survey data to identify harmful practices and to identify trends in practice. The findings are utilized by OSDH to gather information on potentially harmful practices to improve quality of AL services in the state. Case Manager must report Medication issues in a CI.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medication Administration:

In accordance with OAC 310:663-19-2, each Assisted Living Center (AL) shall adopt and adhere to written policies and procedures to ensure safe administration of medications to residents. The AL shall have written policies and procedures for medications administered by AL staff and by non-AL personnel. In addition, the AL shall have policies and procedures that address residents who self-administer medications. The AL policies and procedures to ensure safe administration of medications shall meet the following minimum requirements:

- (1) Medications shall be administered only on a physician's order.
- (2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour of administration.
- (3) An accurate written record of medications administered shall be maintained. The medication record shall include:
 - (A) The identity and signature of the person administering the medication.
 - (B) The medication administered within one hour of the scheduled time.
 - (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method.
 - (D) Adverse reactions or results.
 - (E) Injection sites.
 - (F) An individual inventory record shall be maintained for each Schedule II medication prescribed for a resident.
 - (G) Medication error incident reports.
- (4) A resident's adverse reactions shall be reported at once to the attending physician.

An assisted living center may maintain nonprescription drugs for dispensing from a common or bulk supply if all of the following are accomplished:

- (1) The assisted living center shall have and follow a written policy and procedure to assure safety in dispensing and documenting medications given to each resident.
- (2) The assisted living center shall maintain records which document the name of the medication acquired, the acquisition date, the amount and the strength received for each medication maintained in bulk.
- (3) Only a licensed nurse, physician, pharmacist, certified medication aide or medication aide technician may dispense for administration these medications and only upon a physician's written order for as needed or nonscheduled dosage regimens. The physician's written order shall be maintained in the resident's clinical record.
- (4) Bulk medications shall be stored in the medication area and not in resident rooms.
- (5) The assisted living center shall maintain records of all bulk medications that are dispensed on an individual signed medication administration record.
- (6) The assisted living center shall maintain the original label on the container as it comes from the manufacturer or on the unit-of-use or blister package.
- (7) The assisted living center shall establish in its policy and procedure the maximum size of packaging and shall ensure that each resident receives the correct dosage. The assisted living center shall not acquire nor maintain a liquid medication in a package size that exceeds 16 fluid ounces.
- (8) An assisted living center shall have only oral analgesics, antacids, and laxatives for bulk dispensing. No other category of medication shall be maintained as bulk medication.

Medication Staffing

In accordance with 310:663-9-2, each AL shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. Unlicensed personnel administering medications shall have completed a certified medication aide or medication aide technician training program that has been reviewed and approved by the Department.

Medication Management Quality Assurance

In accordance with 310:663-11-1, each AL shall establish and maintain an internal quality assurance committee that meets at least quarterly. The committee shall:

- (1) monitor trends and incidents;
- (2) monitor customer satisfaction measures; and

- (3) document quality assurance efforts and outcomes.

In accordance with 310:663-11-2, the quality assurance committee shall include at least the following:

- (1) registered nurse or physician if a medical problem is to be monitored or investigated;
- (2) assisted living center administrator;
- (3) direct care staff person or staff person who has responsibility for administration of medications; and
- (4) pharmacist consultant if a medication problem is to be monitored or investigated.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

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

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

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

In accordance with 310:663-19-1, each assisted living center shall record medication errors such as medication given to wrong person, given with no physician’s order on file, wrong dose given, not given within one hour of scheduled time and any adverse reaction to medication whether given appropriately or not. In addition, a resident's adverse reactions shall be reported at once to the attending physician.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Oklahoma State Department of Health (OSDH), the state entity responsible for licensing ALs, provides follow-up and oversight to ensure participant medications are managed appropriately. Annually, the Department conducts unannounced inspections in assisted living centers to determine compliance with state laws and regulations related to medication administration: OAC 310: 663-19-2 et.al, and OAC 310: 675-9-9.1(c). In addition, rules governing medication staffing found at 310:663-9-2(a) and (b) are ensured through personnel record reviews and interviews with staff. Regulations at OAC 310: 663-19-1(a) requires centers to record medication errors, and, 310: 663-11-1 and 2 requires the center to monitor trends and incidents at least quarterly.

The annual inspection protocol includes “Task 5 – Medication Administration.” This protocol is utilized to determine whether the center has adopted written policies and procedures to ensure safe administration of medications to residents. The protocol requires the surveyor to review the center’s policies and procedures for safe medication administration, and surveyors directly observe medication administration to determine whether staff adheres to adopted procedures. Surveyors also review incident reports, clinical records and the AL’s Quality Assurance Committee Pharmacist findings, recommendations and follow-up evaluations to ensure the center has implemented corrective actions when necessary.

Violations of rules are recorded in the survey report provided to the AL. The center has 10 working days after receipt of the notice of violation to file a plan of correction with the Department (OAC 310: 663-25-4 (b)). Within 60 days of the original visit, a revisit survey is conducted to ensure corrective action has successfully removed the deficient practice.

The OSDH medication monitoring gathers information on potentially harmful practices through the medication monitoring survey tools. In addition, the OSDH surveyors review the monthly reports compiled by the Assisted Living consultant pharmacist who documents medication problems such as use of contraindicated medications or adverse medication interactions and medication related errors and incidents. The reports contain both findings and recommendations to the AL’s Quality Assurance Committee to address potentially harmful practices. The OSDH reviews medication monitoring survey data to identify harmful practices and to identify trends in practice. The findings are utilized by OSDH to gather information on potentially harmful practices to improve quality of Assisted Living services in the state.

The findings from the licensing survey reviews, including medication monitoring findings, made available to OHS within 30 days of survey completion. As these reports are received, OHS shares the findings with the Quality Management Strategies Council (QMSC) and OHCA, the Medicaid Agency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number and Percentage of member complaints where investigation initiated within required time frame. Numerator: Number of investigations of member complaints initiated within required time frame Denominator: Total number of member complaints

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

Waiver Management Information System (WMIS) and Escalated Issues (EI) Tracking Logs

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1261 1262 1346" type="text"/>
Other Specify: <input data-bbox="408 1485 647 1570" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1485 1262 1570" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1709 1262 1794" type="text"/>
	Other Specify: <input data-bbox="719 1933 954 2018" type="text"/>	

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percentage of Case Management and/or Home Care Providers who received education on ANE, including how to report. Numerator: Number of Case Management and/or Home Care Providers who received education on ANE, including how to report. Denominator: Total number of Case Management and/or Home Care Providers

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Waiver Management Information System

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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

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

Performance Measure:

Number/Percent of Critical Incidents with Unexplained Death reviewed where root cause was identified to implement systemic interventions to reduce future similar incidents. Numerator: Number of CIs with Unexplained Death reviewed where root cause was identified to implement systemic interventions to reduce future similar incidents. Denominator: Total number of CIs with Unexplained Death reviewed.

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to

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

Performance Measure:

Number and Percentage of ANE/non-ANE Critical Incidents that are appropriately reported and resolved in accordance with policy. Numerator: Number of ANE/non-ANE Critical Incidents appropriately reported and resolved in accordance with policy. Denominator: Number of ANE/non-ANE Critical Incidents.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and Percentage of ANE/non-ANE Critical Incidents (CIs) reviewed with root cause identified in order to implement systemic interventions to reduce future similar incidents. Numerator: Number of ANE/non-ANE CIs reviewed with root cause identified in order to implement systemic interventions to reduce future similar incidents. Denominator: Number of ANE/non-ANE CIs reviewed.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:

Number and Percent of reports from all waiver methods to detect restraints/seclusion in service delivery reported to APS/resolved according to state policy. Numerator: Number of reports from all waiver methods to detect restraints/seclusion in service delivery reported to APS/resolved according to state policy. Denominator: Total number of reports requiring reporting/resolution by APS.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of CM, Home Care, Hospice, ADH and AL providers that have policies in place prohibiting the use of restrictive interventions. Numerator: Number of CM, Home Care, Hospice, ADH and AL providers that have policies in place prohibiting the use of restrictive interventions. Denominator: Number of CM, Home Care, Hospice, ADH and AL providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

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

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 5px auto;">95% confidence level with a +/- 5% margin of error</div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

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

OHCA and OHS dedicated waiver staff are responsible for program monitoring and oversight and will address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OKOHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures.

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

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

The options for remediation of Health and Welfare assurances performance failures are listed below: Remediation for Health and Welfare Assurances:

- Number and Percentage of ANE Critical Incidents that are appropriately reported in accordance with policy.
- Number and Percentage of members that receive education on how to report abuse, neglect and exploitation.
- Number and Percentage of Non-ANE Critical Incidents that are appropriately reported and resolved in accordance with policy.
- Number and Percentage of Case Management and/or Home Care Providers who received education on ANE, including how to report.

The MSU Provider Audit team monitors to ensure that members received education from Case Managers on how to report abuse, neglect and/or exploitation. If any instances are found that a member has not received education on how to report abuse, neglect and exploitation, the OHS MSU Quality Assurance/Improvement staff provides to the Case Management provider a final audit report that includes information regarding this deficiency that requires a corrective action plan. The agency is given 30 days to submit the corrective action plan which must address this education failure and must include immediate resolution for members that are still active. Providers operating under corrective action plans are required to submit monthly Progress Reports for 2 months to the Quality Assurance/Improvement department. At the conclusion of a corrective action cycle, the MSU Provider Audit team performs a follow up audit of the provider.

MSU Escalated Issues team monitors that all member complaint investigations were initiated within the required time frame, that all allegations of member abuse, neglect and/or exploitation were resolved in accordance with state policy and that all critical incidents were appropriately reported and resolved in accordance with policy. For any circumstance in which a member's health or safety is at risk, within one day the Escalated Issues team initiates planning with the member, the Case Manager, Adult Protective Services and others to facilitate member safeguards in the existing environment or relocation to a safer living arrangement and/or transfer to a different service provider, as the situation may warrant. If any instances are found in which a complaint investigation was not initiated within required time frame, an allegation of member abuse, neglect and/or exploitation was not resolved in accordance with policy, or a critical incident was not reported and/or resolved in accordance with policy, the MSU ADvantage Programs Assistant Administrator for Provider/Member Relations contacts directly for resolution the Provider and/or appropriate OHS staff and, if deemed necessary, the Programs Assistant Administrator for Provider/Client Relations will be required to submit, within five working days of request, a corrective action plan to the Programs Administrator of the MSU ADvantage Administration.

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

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="317 618 743 701" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="813 931 1240 1014" type="text"/>

c. Timelines

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

No

Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care

services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Quality Management Strategies Council (QMSC) collaborates for the trending, prioritizing and implementation of system improvement. The Council consists of senior level staff and Quality Assurance/Quality Improvement leadership from OHCA and OHS. The Council meets quarterly to discuss member and provider issues and to set priorities for system-wide quality improvement. The Council receives information from a variety of performance and key indicator reports prepared by OHCA, OHS and the FMS sub-agent. As a result of an analysis of the discovery and remediation information presented to the council, system improvements are identified and design changes are made.

The ADvantage Quality Management Strategy weaves together various quality assurance and quality improvement activities using a three-tiered process:

TIER 1: The first tier involves strategies to ensure service members, advocates, Case Managers, Interdisciplinary Service Planning teams and providers have the tools to develop, implement and monitor quality services. At this level, quality assurance and improvement happens with service members on an ongoing basis and is designed to safeguard service members.

Tier 1 Quality Assurance Processes:

- Provider training
- Case Management supervision and training
- Individual Service Plan development
- Health and Safety Reviews
- Case management monitoring, coordination and reviews
- Grievance procedures
- Fair Hearing procedures
- Community Services Worker Registry pre-employment screenings
- OSBI Criminal Background pre-employment screenings
- Critical Incident System
- Case Manager and Home Care Provider Emergency On-Call Systems

TIER 2: The second tier involves OHS MSU ADvantage Administration, Quality and Eligibility leadership staff, the OHCA Audit and Program Integrity Management Division, as well as committees established to collect and analyze data and make program adjustments to improve service quality. At this level, the strategy is designed to collect and review data from Case Managers, providers, advocates, service members and teams on a wide variety of quality indicators and develop remediation and program improvement strategies to ensure that performance standards and assurances are met.

Tier 2 Discovery and Remediation Processes:

- Administrative Inquiries
- Ethic of Care Committee (EOCC) reviews
- Critical Incident and Escalated Issues reviews
- Case Management Violation Review Committee findings
- Morbidity and Mortality review data
- Member Satisfaction Surveys
- Data extracts from plan of care authorization database and paid claims history
- WMIS database reports
- CMS Assurances Performance Measures and Remediation reports
- OHCA Surveillance and Utilization Review Systems
- OHCA Audit and Management Division retrospective audit reviews
- Provider monitoring

TIER 3: The third tier involves OHS MSU Executive and State Office Executive staff and OHCA Waiver Administration and Development staff. A Quality Management Strategy Council (QMSC) reviews findings and activities from Tier 2. The Council develops strategies for system improvement, establishes priorities, compiles and communicates Quality Management Reports and evaluates and revises the Quality Management Strategy annually.

Tier 3 Quality Management Processes:

- Compile and analyze Tier 2 activities
- Develop and prioritize system improvement strategies
- OHS Published Annual Report
- Complete Annual Quality Management Strategy Review and Revision

Effective compilation and communication of quality management information requires an appropriate infrastructure that is designed for that purpose. The backbone of support for ADvantage Quality Improvement Strategy (QIS) consists of two integrated relational databases and their associated subsystems for criteria-based evaluation and output systems for report/notification – the Medicaid Management Information System (MMIS) and Waiver Management Information System (WMIS).

The QMSC reviews quarterly system quality assessment reports and may develop recommendations for revision and/or addition of system quality monitoring and/or improvement projects. Annually, all QMSC system changes are incorporated into the QIS description that is filed as part of the 372 reporting cycle for the waiver.

Comparative data that is gleaned from MMIS and WMIS is evaluated by the QMSC to determine if system changes are warranted. Review of these reports may also lead to initiation of new improvement projects to benefit waiver members.

The following general processes and criteria guide the setting of priorities in implementing system improvements:

Prioritization

The ADvantage Program prioritizes quality improvement activities and projects from those opportunities that provide the most benefit to the member, the community, stakeholders, system, organization, and funding entities, at the same time maximizing use of quality improvement resources. Consideration is given to the issues based on the following criteria:

- 1) Regulatory Requirements - required by law or funding sources;
- 2) High Risk - likelihood of adverse events or outcomes;
- 3) High Volume - affects many individuals;
- 4) High Cost - causes financial drain on system;
- 5) High Impact - potential to make significant change;
- 6) High Likelihood of Success - easy to implement and provides successful outcome;
- 7) Problem Prone - causes major problems if it occurs;
- 8) Feasibility of Time and Resources - cost/staff commitment required;
- 9) Measurability - data and resources can capture necessary information; and
- 10) Readiness to Address Issue - the time, situation, and climate are right.

After the QMSC has identified a need for system improvement and decided action is needed, the design and development of the processes for implementing the system improvement is accomplished by the administrative unit that is responsible for the ADvantage administrative function working in concert with a QMSC subcommittee created to advise and track progress of the implementation of the systems improvement project.

Progress on system improvement projects is reported during QMSC quarterly meetings and shared with MSU staff, providers and other stakeholders with primary interest in the area targeted for improvement efforts.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div data-bbox="320 551 868 622" style="border: 1px solid black; height: 30px; width: 100%;"></div>	Other Specify: <div data-bbox="940 551 1487 622" style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. System Design Changes

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

In addition to tracking and evaluating performance measures and other key indicators of quality for established functions, the QMSC likewise tracks and assesses system improvement projects and system design changes. These changes may evolve from analysis and evaluation of evidence discovered through performance measure trends or from remediation detail or reoccurring root causes of failures leading to remediation. Or they may derive from other key quality indicators such as particular issues prompting one or more fair hearings, etc.

For each system improvement project or system design change, the QMSC creates a subcommittee to track the progress of the improvement/change implementation and to measure outcomes related to that change. Since each improvement/change derives from informed evaluation of a prior condition related to quality of service/function, measures are derived, if not already existing, from the past and current condition to serve as a baseline for future evaluation of improvement/change impact.

The QMSC design improvement subcommittee consults with administrative program staff of the unit responsible for implementing the improvement/design change and for collecting performance measures post design change. During the process of measure definition, the subcommittee determines sources of data and whether data collection for the measure will be based upon 100% or a random sample and the frequency of data aggregation/analysis/reporting. In addition, the subcommittee in consultation with the administrative unit determines the time-frame during which a meaningful and measurable change in quality can reasonably be expected after implementation of the system improvement/change. The measures, data sources, sampling and reporting procedures will be evaluated and approved the design improvement subcommittee prior to improvement design change implementation. The chairperson of the design improvement subcommittee will present a summary of the improvement design change, measures for tracking design change impact and procedures for data collection and analysis to the QMSC during quarterly meetings.

The QMSC discusses and evaluates the trends and documented progress or lack of progress in quality being addressed by the improvement/design change. After the time period initially projected to be reasonably sufficient to detect a beneficial change has elapsed, the QMSC formally evaluates progress and determines whether the improvement/change appears to be achieving its objective or whether more time may be needed to determine success or whether some tweaking of the implementation strategy may be needed or whether the effort has clearly failed and a different approach needs to be considered. If the effort appears to be succeeding, the improvement/change is formally evaluated again after a total elapsed time period that is double the initial projected time-frame projected to be sufficient to detect a beneficial impact. At this second evaluation a determination will be made as to the improvement/design change success and if not successful, what different approach could be taken to achieve improvement. With adoption of a different improvement/design change implementation, the cycle is repeated.

The QMSC reports system improvement/design change projects and outcomes during its regular meetings. These reports are shared with administrative unit leads and with stakeholders directly involved in the system change effort. In addition, the QMSC describes and summarizes all system improvement/design change projects and outcomes in the ADvantage Annual Report on Quality. This report is distributed to interested parties including the OHCA Board and Aging Services Citizens Advisory Panel, members of the state legislature, and is posted on the OHCA and OHS websites for access by service members and their families, advocates, and members of the general public.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Management Strategies Council (QMSC) meets quarterly to review and analyze information from the previous quarters and to review progress of system improvement projects. Quality measure trends and issues are presented, discussed, and evaluated to inform decisions on additional actions to improve quality. The QMSC periodically reviews and evaluates the QIS performance measures, sampling strategies, and processes for remediation and improvement. The evaluation compares performance to anticipated benchmark performance, analyzes trends in performance, and analyzes remediation reports to identify systemic failures and reviews reports and descriptions of best-practice quality improvement approaches from other states for applicable practice to addressing performance issues in ADvantage. Based upon evaluation, the QMSC may identify areas in need of improvement and decide upon modification to existing strategies or development and implementation of additional improvement strategies. The QMSC evaluates the Quality Management Strategy at least annually and revises it as necessary.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) *The Operating Agency MSU performs financial assessments of the waiver service providers as part of a more comprehensive provider certification/annual recertification process. The financial assessment reviews end of year financial statements (liabilities, assets & equity – balance sheet) for the most recently completed fiscal year of operation. Service providers are not required to secure an independent audit of their financial statements.*

(b) *OHCA Program Integrity and Accountability conducts annual audits on waiver services that consist of a review of paid claims designed to detect overpayments as a result of fraud, waste, or abuse. Most audits are desk review; however, Program Integrity conducts audits both through desk and onsite review. During the analysis of claims and evaluating overall risk of fraud, waste, or abuse, it is determined if the audit will be a desk or onsite review. Potential risks that could warrant an onsite audit include, but are not limited to, the risk for records to be created or altered for the audit, records not being submitted as complete if requested for a desk review or noncompliance with a records request, potential of record destruction, and potential for practice abandonment.*

The difference between the two types is the manner in which records are collected. In a desk review, the provider is notified via mail of the audit and is given a list of members, dates of service, and required documentation which must be submitted for review. An onsite audit may be announced (2-week notice) or unannounced (no notice). A detailed listing of members, dates of service, and required documentation is given to the provider and all documentation must be submitted to the audit team during the onsite audit. For both audit types, records are reviewed in office and the provider is notified by mail through an error letter (audit report) of the results. A detailed spreadsheet of claims in error and any identified overpayment amount is included. All audits, regardless of service type, follow the same audit process to verify services billed were performed by appropriately qualified personnel and in compliance with all state and federal regulations/policies.

When inappropriate claims are identified, they are removed from claims for FFP by OHCA through a process of voiding the inappropriate claims and recouping paid claims from the provider. When overpayments are identified, the federal share is returned to CMS on the quarterly CMS 64 report.

(c) *The Operating Agency MSU performs financial assessments for a representative random sample of members. Number of members selected have a confidence level equal to 95% with a +/- 5% margin of error. All claims submitted per member per quarter are reviewed, which includes all service providers included on members' service plans who submit claims during the quarter. Claims are reviewed against member eligibility, dates of service consistent with prior authorization dates and current service rates. Anomalies are rare and all are investigated. When needed, corrections are made to member records (usually case number changes for members who move from disabled to aged). Whenever necessary, inappropriate claims are recouped by OHCA.*

When inappropriate claims are identified by the MSU through prior authorization errors identified within the waiver management information system (WMIS), the provider agency is contacted and requested to back out their billing within 10 business days. For those providers that do not back out their billing timely, a monthly list is sent to OHCA identifying the claims and requesting recoupment.

(d) *OHCA Program Integrity and Accountability is responsible for conducting financial audits. The entity that is responsible for the independent audit under the Single Audit Act in Oklahoma is the Office of the State Auditor and Inspector. This agency performs annual audits separately and apart from the operating agency (OHS) and the Medicaid agency (OHCA).*

(e) *The state has an approved Electronic Visit Verification (EVV) system in place. ADvantage waiver services subject to EVV requirements include: personal care; advanced supportive/restorative assistance; in-home and extended in-home respite; self-directed and advanced self-directed personal assistance (self-directed) services; skilled nursing (RN and LPN); extended state plan skilled nursing (RN and LPN); and RN assessment/evaluation service.*

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number and percent of service providers that use the EVV system for financial management and recordkeeping practices as required by state policy for in-home services. Numerator: Number of service providers that use the EVV system for financial management and recordkeeping practices as required by state policy for in-home services. Denominator: Total number of in-home service providers.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percentage of waiver claims that are coded and paid for in accordance with the approved waiver based on date of service delivery and only for services rendered.

Numerator: Number of waiver claims that are coded and paid for in accordance with the approved waiver based on date of service delivery and only for services rendered.

Denominator: Total number of waiver claims evaluated.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <i>95% confidence level with a +/- 5% margin of error</i> </div>
<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>	<i>Annually</i>	<i>Stratified Describe Group:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>
	<i>Other Specify:</i> <input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

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

Performance Measures

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

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

Performance Measure:

Number & percentage of waiver service claims paid that maintain rates consistent with the approved rate methodology throughout the five year waiver cycle. Numerator: Number of waiver service claims paid that maintain rates consistent with the approved rate methodology throughout the five year waiver cycle. Denominator: Number of waiver service claims paid that are reviewed.

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence interval with a +/- 5% margin of error </div>

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

OHCA and OHS dedicated waiver staff are responsible for program monitoring and oversight and will address individual problems as they are discovered with regard to operations and administrative functions that are performed by all contracted entities. The OHCA dedicated waiver staff will maintain administrative authority through the use of an electronic database designed for storing information received related to problems identified and resolutions of these matters. The OHCA Director of Waiver Administration and Development will be directly responsible for mediating any individual problems pertaining to administrative authority. The Director of Waiver Administration and Development will work with the designated OHS Point of Contact to resolve any problems in a timely manner. Problems requiring system change or additional staff will be addressed through the ADvantage Quality Management Strategies Council (QMSC) which may form workgroups involving appropriate personnel to resolve issues more timely and effectively or to initiate systemic changes to address re-occurring issues/performance failures.

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

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

The options for remediation of Financial Accountability assurances performance failures are listed below:

Remediation for Financial Accountability Assurances:

- Number and Percentage of claims paid in accordance with waiver reimbursement methodology
- Number and percentage waiver claims paid for members enrolled in the waiver on the date that the service was delivered

The OHCA Program Integrity and Accountability Unit monitors that ADvantage member claims are paid in accordance with waiver policy and that claims only for members enrolled when services are delivered. If any instances are found that a claim has been paid inappropriately either due to not being in accordance with approved reimbursement methodology or for services delivered to a non-enrolled member, the OHCA Director of Program Integrity and Accountability contacts directly for resolution the appropriate OHCA staff and, if deemed necessary, the Director of Program Integrity and Accountability will be required to submit, within five working days of request, a corrective action plan to the Director of Waiver Administration and Development. Any reimbursements for claims found to have been inappropriately paid are recouped from providers.

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

ii. Remediation Data Aggregation

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

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

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

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).

Every three years, the Oklahoma Health Care Authority completes an Access Monitoring Review Plan (AMRP). The OHCA is committed to continuous quality improvement with respect to services and beneficiaries, while maintain an extensive provider base. Since the Agency's first AMRP, OHCA continues to focus on access to care for its members by establishing new services and rate increases for providers. In general, unless noted by policy change, most year-to-year fluctuations in provider counts are from temporary decreases due to contract renewal periods, especially in regard to out-of-state providers, or it's due to changes in the methodology of how provider types and specialties are counted.

Service rates were last reviewed in June 2019 with the last rebasing of rates effective on 10/1/2019.

All rates are taken to a public Tribal Consultation, a public rate hearing, a public notice, and taken to a public OHCA Board meeting. Feedback is taken from providers on rates and rate methods. Additionally, the OHCA's Member and Provider Services Unit take calls from members and providers when there are access issues. If there is a continual problem with rates, rate methods can be changed accordingly based on the feedback. Also, care managers speak directly with members and can locate resources if they are having difficulty gaining access to services.

Further, the AMRP demonstrates the Agency's compliance with 1902(a)(30)(A) of the SSA, which assures state payments are consistent with efficiency, economy, and quality of care sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that those services are available to the general public.

The OHCA State Plan Amendment Rate Committee (SPARC) is responsible for reviewing and setting all service rates for Medicaid services. Rates are given final consideration and approval by the OHCA Board.

All services and associated rates are accessible to the general public through publication on the OHCA and OHS websites.

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

1) *Method One - Utilizing the Medicaid Rate:* When a waiver service is similar to or the same as a Medicaid service for which a fee schedule has been established, the current Medicaid rate is utilized. Services utilizing the established Medicaid rate are:

- a) *Facility Based Respite Care:* Reimbursement for this service is made at the current daily rate for nursing facility care.
- b) *Personal Care Services:* Payment is made at the rate established for State Plan Personal Care services.
- c) *In-home 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) *Medical Equipment and Supplies*

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

2) *Method Two - Fixed and Uniform Rate:* Title 74 of the Oklahoma Statutes provides a methodology for setting fixed and uniform rates.

- a) *Determination of need for a fixed and uniform rate*
 - i) *New:* A new service is developed, or
 - ii) *Existing Service:* Feedback from providers, members, or the general public indicates that the existing rate is not sufficient to ensure access to an existing service.
- b) *Preparation of a Rates and Standards Brief:*
 - i) *Preparation:* Staff prepares a position paper that at a minimum includes a description of the service, the payment history including rates and utilization, the methodology utilized to arrive at the proposed rate, and a description of the funding source.
 - ii) *Public Hearing:* A public hearing notice is prepared and a hearing is scheduled.
 - iii) *Oklahoma Office of Central Services:* Copies of the public hearing notice, the Rates and Standards Brief and any other pertinent data is delivered to the Oklahoma Office of Central Services at least 30 days before the date of the public hearing. The Director of the Department of Central Services shall communicate any observation, reservation, criticism

or recommendation to the agency, either in person at the time of the hearing or in writing delivered to the State agency before or at the time of the hearing.

c) *Public Hearing Notice: Notice of public hearing will be provided in the following:*

- i) *Posted in the office of the Secretary of State*
- ii) *Posted by the Oklahoma Health Care Authority at its physical location and on the web site calendar*
- iii) *Published by the Oklahoma Health Care authority in various Newspaper publications across Oklahoma.*

d) *Public Hearing:*

i) *Committee: The public hearing is conducted by the Rates and Standards Committee of the Oklahoma Health Care Authority. The committee is comprised of staff from the OHCA and Oklahoma Human Services (OHS).*

ii) *Public comment: All attendees of the public hearing are offered an opportunity to voice their opposition or approval of the proposed rates. All comments become part of the permanent minutes of the hearing.*

e) *Final Approval: The rate is then scheduled for consideration and approval by the Board of Directors of the OHCA prior to implementation.*

f) *ADvantage services set by fixed, uniform rate setting are:*

- i) *Case Management*
- ii) *Nursing*
- iii) *Therapy Services*
- iv) *Adult Day Health (ADH) Care, including Therapy in ADH, Personal Care in ADH, and Laundry in ADH.*
- v) *Home Delivered Meals*
- vi) *Advance Supportive/Restorative Assistance*
- vii) *Assisted Living Services*
- viii) *Hospice*
- ix) *Skilled Nursing*
- x) *Institution Transition (Transitional Case Management) Services*
- xi) *In-home Extended Respite*

3) *Method 3 - Individual Rates: Certain services because of their variability 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. These services are:*

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. Requests under \$2500 are reviewed by a clinical nurse to ensure service rates are reasonable and consistent with similar service requests. Any request over \$2500 requires submission of three bids and review by a clinical nurse.*

b) *Consumer-Directed Personal Supports and Services. Methodology for these rates include an analysis of the comparable payments to agencies. OHS/AS sets the Personal Services Assistance (PSA) rates and the Advanced Personal Services Assistance (APSA) rates at a level that is not less than 80% and not more than 95% of the comparable agency personal care (for PSA) or advanced supportive/restorative (for APSA) service rates. A range of payments per hour is then calculated for member consideration when hiring the member-directed personal services assistance or advanced personal services assistance. This provides the member the flexibility as employer to pay different salaries to different workers within programmed defined limits.*

c) *Personal Emergency Response Systems. Methodology for these rates vary depending on the location of the member and the provider. All requests for PERS are reviewed by service plan analysts to ensure rates are consistent statewide within a narrow range for both installation and monthly service costs.*

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider claims for waiver services are filed directly with the OHCA fiscal agent. 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.

Personal care providers are required to use the Electronic Visit Verification (EVV) system, and personal care services (PCS) are documented solely through the EVV system with the possible exception of live-in paid caregivers. The EVV system provides alternate backup solutions when the automated system is unavailable. In the event of EVV system failure, the provider documents time in accordance with internal policy and procedures. This documentation suffices to account for in-home and office services delivered. Provider agency backup procedures are only permitted when the EVV system is unavailable.

Prior authorizations are submitted via a secure electronic file from the ADvantage WMIS to MMIS and are subsequently routed to the EVV system. Upon service delivery, a claim is submitted to MMIS via an 837 format.

OHCA has implemented a statewide aggregator for EVV to be in compliance with the 21st Century Cures Act.

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 according to the above criteria. When problems with validation are identified on the post payment review, erroneous or invalidated claims are voided from the claims payment system. These claims are then recouped from the provider by OHCA. When overpayments are identified, the federal share is returned to CMS on the quarterly CMS 64 report.

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:

[Empty rectangular box]

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:

[Empty rectangular box]

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The FMS receives payment as the limited fiscal agent for self-directed services. Services that can be self-directed include: CD-PASS Personal Services Assistance and Advance Personal Services Assistance. The limited Fiscal Agent performs the following functions:

- 1. Assists member in verifying support worker citizen status,*
- 2. Collects and processes timesheets of support workers,*
- 3. Processes payroll, withholding, filing and payment of applicable federal, state and local employment related taxes and insurance.*

In addition, according to the needs and desires of the member the FMS may provide orientation and training regarding employer responsibilities as well employer information and management guidelines, materials, tools and staff consultant expertise to support and assist the member in successfully performing employer-related functions. OHS is IRS fiscal agent and has direct contract monitor responsibility for overseeing the operations of the limited fiscal sub-agent.

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

[Empty rectangular box]

Appendix I: Financial Accountability

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The University of Oklahoma College of Nursing and several local Council of Governments provide Case Management services for individuals enrolled in the Advantage Waiver.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of

the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

Oklahoma does not restrict reassignment to any specific agency.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCD; (d) the method(s) for assuring that providers that furnish services under contract with an OHCD meet applicable provider qualifications under the waiver; (e) how it is assured that OHCD contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCD arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

State share funding for services provided under all of Oklahoma’s HCBS Waiver Programs is from General Fund Appropriations from the State Legislature made to two (2) State Agencies.

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

On a weekly basis, the OHCA submits a billing to the OHS for the State share dollars for all Waiver services (except “prescription drugs”) for which provider claims were processed/paid. Through an inter-Agency transfer, these State share funds are then deposited into the OHCA’s general fund. The transfer of these funds represents a repayment to the OHCA, since the OHCA had already paid all provider service claims “in full”.

Other State Level Source(s) of Funds.

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

Appendix I: Financial Accountability

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

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

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

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

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Assisted Living Services Reimbursement Rate Determination

The only residential facilities in which ADvantage members are allowed to receive services (other than respite in a NF) are Assisted Living Centers approved to provide ADvantage Assisted Living services. In these circumstances, Assisted Living Services reimbursement rates are determined solely on costs of services and exclude room and board costs which are paid for separately by the member.

The reimbursement rate for Assisted Living services follows three service need-based tiers with providers reimbursed at the tier the member is assessed to need. The cost for room with associated facility utility and maintenance costs and the cost for food for meals have been excluded from these reimbursement rates. The following guidelines were used when developing the provider rates:

Room and board costs are excluded from provider reimbursement rate determination;

Only costs for ADvantage Assisted Living services are considered in development of reimbursement rate; The reimbursement rate needs to be attractive enough to encourage providers to participate;

The rate needs to reimburse Assisted Living Services providers at a level adequate to support staffing capacity required to provide quality care and 24 hour staffing;

The reimbursement rate needs to be realistically determined taking into consideration the varying need levels of members with ADLs and IADLs as well as specialized care related to daily medical needs, and;

The reimbursement rate for Assisted Living Services needs to be established so that there is a reasonable expectation that a service plan can be developed to meet a member's additional ADvantage service needs within the cost constraints of the waiver.

Room and Board Payments:

Members will pay their room and board expenses directly to the Assisted Living Center, which will determine the room and board charge. The ADvantage Assisted Living provider is required to execute an Admission Agreement with each ADvantage member and is prohibited from modifying the room and board charge without providing at least 30 days prior written notice to the member.

Minimally, members receiving ADvantage services in the Assisted Living setting will have an income comprised of SSI and State Supplemental Payment (SSP) available to pay for room and board. If the member is an SSI recipient ADvantage rules restrict the allowable maximum room and board charges to be equal to the SSI payment.

Appendix I: Financial Accountability**I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

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

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

Some waiver recipients, who have elected the Assisted Living service option, may pay a vendor co-payment to the facility, depending on their income.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

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

Waiver Service	Charge
<p><i>Prescribed Drugs</i></p>	<p>Amount:</p> <div style="border: 1px solid black; padding: 5px;"> <p>\$0.00 for preferred generics. \$0.65 for cost of \$0.00-\$10.00 \$1.20 for cost of \$10.01-\$25.00 \$2.40 for cost of \$25.01-\$50.00 \$3.50 for cost of \$50.01 or more</p> </div> <p>Basis:</p> <div style="border: 1px solid black; padding: 5px;"> <p>\$0.00 for preferred generics. \$0.65 for prescriptions having a Medicaid allowable payment of \$0.00-\$10.00. \$1.20 for prescriptions having a Medicaid allowable payment of \$10.01-\$25.00. \$2.40 for prescriptions having a Medicaid allowable payment of \$25.01-\$50.00 and \$3.50 for prescriptions having a Medicaid allowable payment of \$50.01 or more. Co-payments are for members 21 and older.</p> </div>
<p><i>Assisted Living Services</i></p>	<p>Amount:</p> <div style="border: 1px solid black; padding: 5px;"> <p>Amount Varies with COLA</p> </div> <p>Basis:</p> <div style="border: 1px solid black; padding: 5px;"> <p>Total counted income (Gross Income minus Medicaid Income Pension Trust). MINUS assisted living maintenance standard (150% of SSI Federal Benefit Rate). MINUS Medicare premium and health insurance premiums. MINUS other health insurance premiums. MINUS deemed or diverted income (Income diverted to Community Spouse). EQUALS Vendor co- payment.</p> </div>

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: 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	7726.71	5498.00	13224.71	43002.00	3083.00	46085.00	32860.29
2	8034.30	5607.96	13642.26	44932.79	3083.00	48015.79	34373.53
3	8365.52	5720.12	14085.64	46950.27	3083.00	50033.27	35947.63
4	8716.63	5834.52	14551.15	49058.34	3083.00	52141.34	37590.19
5	9082.61	5951.21	15033.82	51261.06	3083.00	54344.06	39310.24

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:
		Nursing Facility

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:	
		Nursing Facility	
Year 1	24375		24375
Year 2	24375		24375
Year 3	24375		24375
Year 4	24375		24375
Year 5	24375		24375

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 (ALOS) is calculated by dividing the total number of "enrolled days" for all waiver members by the number of unduplicated members served during a waiver year.

For the waiver renewal the ALOS estimate is based on the average of the 372 reports from fiscal years 2017 through 2019 and the preliminary 372 report for FY 2020.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D estimate for service rates for WY 1 were based on CMS 372 data for FY 19, factoring in a 4% rate increase due to a legislative mandate. Factor D estimate of rates for waiver years 2 to 5 were completed using a 2% annual increase consistent with the Bureau of Labor Statistics (BLS) Consumer Price Index for years 2017 and 2018. The BLS reflects an increase in the CPI of 2.1% for 2017 and an increase of 1.9% for 2018, the average of which is 2.0%.

Factor D estimate for number of users for WY 1 was based on 372 data for FY 19 and preliminary 372 data for FY 20. As a result, the number of users remained unchanged from WY 1 through WY 5.

The AL service was increased by 13% for waiver years 1 through 5 based on an average growth of 13% per year according to 372 report data from FY 2017 through 2019 and FY 2020 Preliminary 372 report due to an increase of newly certified and contracted Assisted Living Centers.

Average units per user was based on the utilization identified in Preliminary 372 report for FY 2020 and remains the same across waiver years 1-5.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' for Waiver Year 1 was based on FY 2019 Form 372 and is increased annually by 2% for waiver years 2 to 5 consistent with the Bureau of Labor Statistics (BLS) Consumer Price Index for years 2017 and 2018. The BLS reflects an increase in the CPI of 2.1% for 2017 and an increase of 1.9% for 2018, the average of which is 2.0%.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G for Waiver Year 1 is based on FY 2019 Form 372. Factor G estimates for waiver years 2 to 5 are increased by 4.49% per year based on the average of Factor G Estimate increases from 372 reports for FYs 17, 18 and 19.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' for Waiver Year 1 is based on FY 2019 Form 372. The average of Factor G Estimate increases from 372 reports for FYs 17, 18 and 19 is 0.016%. As the percentage amount is not statistically significant, Factor G' has been maintained at the same level for all waiver years.

Appendix J: Cost Neutrality Demonstration

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

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

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

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. **Estimate of Factor D.**

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1909616.59
Adult Day Health (ADH)	15 minutes	335	2730.40	2.08	1902542.72	
Therapy in ADH	1 Session	1	24.00	11.70	280.80	
Personal Care in ADH	1 Session	18	45.11	8.27	6715.07	
Laundry in Adult Day Health	1 Session	1	10.00	7.80	78.00	
Case Management Total:						49067789.84
Case Management	15 minutes	20007	121.99	15.29	37317598.59	
Very Rural Case Management	15 minutes	4368	122.89	21.89	11750191.25	
Personal Care Total:						67105776.41
Personal Care	15 minutes	16577	961.55	4.21	67105776.41	
Respite Total:						334014.63
In-Home Respite	15 minutes	92	388.93	4.21	150640.37	
Extended In-Home Respite	1 Day	2	14.00	175.55	4915.40	
Nursing Facility Respite	1 Day	59	17.23	175.55	178458.86	
Extended State Plan Skilled Nursing Total:						3382.91
Registered Nurse Extended State Plan Skilled Nursing	15 minutes	3	59.84	15.60	2800.51	
Licensed Practical Nurse Extended State Plan Skilled Nursing	15 minutes	2	20.00	14.56	582.40	
Prescribed Drugs Total:						3702046.04
Prescribed Drugs	1 Each	2387	20.30	76.40	3702046.04	
Advanced Supportive/Restorative Assistance Total:						859317.81
Advanced Supportive/Restorative Assistance	15 minutes	288	660.12	4.52	859317.81	
Assisted Living Services Total:						8719148.43
GRAND TOTAL:						188338537.90
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						7726.71
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier Two	1 Day	156	165.63	66.11	1708168.69	
Tier Three	1 Day	410	146.57	92.47	5556864.44	
Tier One	1 Day	158	187.86	48.99	1454115.30	
Consumer-Directed Personal Assistance Supports and Services Total:						11881779.36
Personal Services Assistance (PSA)	15 minutes	1473	2003.32	3.56	10505169.68	
Goods & Services	1 item	982	228.73	1.04	233597.37	
Advanced PSA	15 minutes	233	1148.86	4.27	1143012.30	
Environmental Accessibility Modifications Total:						568723.10
Environmental Accessibility Modifications	1 project	85	1.00	6690.86	568723.10	
Home-Delivered Meals Total:						22041236.92
Home-Delivered Meals	1 Meal	15419	277.57	5.15	22041236.92	
Hospice Care Total:						454419.04
Hospice Care	1 Day	49	74.91	123.80	454419.04	
Institution Transition Services Total:						26717.49
Transitional Case Management	15 minutes	47	6.59	15.29	4735.77	
Very Rural Transitional Case Management	15 minutes	179	5.61	21.89	21981.72	
Nursing Total:						3927867.28
Nursing Assessment / Evaluation	15 minutes	19463	8.91	15.60	2705279.15	
Registered Nurse Skilled Nursing	15 minutes	1043	32.83	15.60	534170.36	
Licensed Practical Nurse Skilled Nursing	15 minutes	822	57.52	14.56	688417.77	
Personal Emergency Response Systems Total:						1059553.01
PERS Installation	1 year	834	1.00	47.12	39298.08	
PERS Monthly					1020254.93	
GRAND TOTAL:						188338537.90
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						7726.71
Average Length of Stay on the Waiver:						299

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 month	3963	8.27	31.13		
Specialized Medical Equipment and Supplies Total:						16676483.42
Specialized Medical Equipment and Supplies	1 item	17220	940.23	1.03	16676483.42	
Therapy Services Total:						665.60
Physical Therapy	15 minutes	1	16.00	20.80	332.80	
Occupational Therapy	15 minutes	1	16.00	20.80	332.80	
GRAND TOTAL:						188338537.90
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						7726.71
Average Length of Stay on the Waiver:						299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						1981079.80
Adult Day Health (ADH)	15 minutes	341	2730.40	2.12	1973860.77	
Therapy in ADH	1 Session	1	24.00	11.93	286.32	
Personal Care in ADH	1 Session	18	45.11	8.44	6853.11	
Laundry in Adult Day Health	1 Session	1	10.00	7.96	79.60	
Case Management Total:						50060577.31
Case Management	15 minutes	20007	121.99	15.60	38074201.31	
Very Rural Case Management	15 minutes	4368	122.89	22.33	11986376.00	
Personal Care Total:						69750462.00
GRAND TOTAL:						195836054.44
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8034.30
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	15 minutes	16909	961.55	4.29	69750462.00	
Respite Total:						346965.82
In-Home Respite	15 minutes	94	388.93	4.29	156839.91	
Extended In-Home Respite	1 Day	2	14.00	179.06	5013.68	
Nursing Facility Respite	1 Day	60	17.23	179.06	185112.23	
Extended State Plan Skilled Nursing Total:						3450.16
Registered Nurse Extended State Plan Skilled Nursing	15 minutes	3	59.84	15.91	2856.16	
Licensed Practical Nurse Extended State Plan Skilled Nursing	15 minutes	2	20.00	14.85	594.00	
Prescribed Drugs Total:						3852118.87
Prescribed Drugs	1 Each	2435	20.30	77.93	3852118.86	
Advanced Supportive/Restorative Assistance Total:						891643.89
Advanced Supportive/Restorative Assistance	15 minutes	293	660.12	4.61	891643.89	
Assisted Living Services Total:						10060541.86
Tier Two	1 Day	176	165.63	67.43	1965643.84	
Tier Three	1 Day	464	146.57	94.32	6414559.83	
Tier One	1 Day	179	187.86	49.97	1680338.19	
Consumer-Directed Personal Assistance Supports and Services Total:						12352700.23
Personal Services Assistance (PSA)	15 minutes	1502	2003.32	3.63	10922621.50	
Goods & Services	1 item	1002	228.73	1.06	242938.71	
Advanced PSA	15 minutes	237	1148.86	4.36	1187140.02	
Environmental Accessibility Modifications Total:						586896.68
Environmental Accessibility Modifications	1 project	86	1.00	6824.38	586896.68	
GRAND TOTAL:					195836054.44	
Total Estimated Unduplicated Participants:					24375	
Factor D (Divide total by number of participants):					8034.30	
Average Length of Stay on the Waiver:					299	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home-Delivered Meals Total:						22919510.04
Home-Delivered Meals	1 Meal	15728	277.57	5.25	22919510.04	
Hospice Care Total:						472981.74
Hospice Care	1 Day	50	74.91	126.28	472981.74	
Institution Transition Services Total:						27733.97
Transitional Case Management	15 minutes	48	6.59	15.60	4934.59	
Very Rural Transitional Case Management	15 minutes	182	5.61	22.33	22799.38	
Nursing Total:						4086586.23
Nursing Assessment / Evaluation	15 minutes	19852	8.91	15.91	2814181.80	
Registered Nurse Skilled Nursing	15 minutes	1064	32.83	15.91	555754.12	
Licensed Practical Nurse Skilled Nursing	15 minutes	839	57.52	14.85	716650.31	
Personal Emergency Response Systems Total:						1102217.10
PERS Installation	1 year	851	1.00	48.06	40899.06	
PERS Monthly	1 month	4042	8.27	31.75	1061318.04	
Specialized Medical Equipment and Supplies Total:						17339909.71
Specialized Medical Equipment and Supplies	1 item	17564	940.23	1.05	17339909.71	
Therapy Services Total:						679.04
Physical Therapy	15 minutes	1	16.00	21.22	339.52	
Occupational Therapy	15 minutes	1	16.00	21.22	339.52	
GRAND TOTAL:						195836054.44
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8034.30
Average Length of Stay on the Waiver:						299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2060131.33
Adult Day Health (ADH)	15 minutes	348	2730.40	2.16	2052387.07	
Therapy in ADH	1 Session	1	24.00	12.17	292.08	
Personal Care in ADH	1 Session	19	45.11	8.60	7370.97	
Laundry in Adult Day Health	1 Session	1	10.00	8.12	81.20	
Case Management Total:						51053364.78
Case Management	15 minutes	20007	121.99	15.91	38830804.03	
Very Rural Case Management	15 minutes	4368	122.89	22.77	12222560.75	
Personal Care Total:						72637275.48
Personal Care	15 minutes	17247	961.55	4.38	72637275.48	
Respite Total:						363758.21
In-Home Respite	15 minutes	96	388.93	4.38	163537.29	
Extended In-Home Respite	1 Day	2	14.00	182.64	5113.92	
Nursing Facility Respite	1 Day	62	17.23	182.64	195107.01	
Extended State Plan Skilled Nursing Total:						3519.61
Registered Nurse Extended State Plan Skilled Nursing	15 minutes	3	59.84	16.23	2913.61	
Licensed Practical Nurse Extended State Plan Skilled Nursing	15 minutes	2	20.00	15.15	606.00	
Prescribed Drugs Total:						4006685.50
Prescribed Drugs	1 each	2483	20.30	79.49	4006685.50	
Advanced Supportive/Restorative Assistance Total:						927666.64
Advanced Supportive/Restorative Assistance	15 minutes	299	660.12	4.70	927666.64	
Assisted Living Services Total:						11590395.38
GRAND TOTAL:						203909636.15
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8365.52
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier Two	1 Day	199	165.63	68.78	2267014.25	
Tier Three	1 Day	524	146.57	96.21	7389185.84	
Tier One	1 Day	202	187.86	50.97	1934195.29	
Consumer-Directed Personal Assistance Supports and Services Total:						12842509.21
Personal Services Assistance (PSA)	15 minutes	1532	2003.32	3.70	11355619.09	
Goods & Services	1 item	1022	228.73	1.08	252463.02	
Advanced PSA	15 minutes	242	1148.86	4.44	1234427.09	
Environmental Accessibility Modifications Total:						612582.96
Environmental Accessibility Modifications	1 project	88	1.00	6961.17	612582.96	
Home-Delivered Meals Total:						23866889.76
Home-Delivered Meals	1 Meal	16042	277.57	5.36	23866889.76	
Hospice Care Total:						492068.81
Hospice Care	1 Day	51	74.91	128.80	492068.81	
Institution Transition Services Total:						28897.08
Transitional Case Management	15 minutes	49	6.59	15.91	5137.50	
Very Rural Transitional Case Management	15 minutes	186	5.61	22.77	23759.58	
Nursing Total:						4251919.01
Nursing Assessment / Evaluation	15 minutes	20249	8.91	16.23	2928193.72	
Registered Nurse Skilled Nursing	15 minutes	1086	32.83	16.23	578654.36	
Licensed Practical Nurse Skilled Nursing	15 minutes	855	57.52	15.15	745070.94	
Personal Emergency Response Systems Total:						1146957.99
PERS Installation	1 year	868	1.00	49.02	42549.36	
PERS Monthly					1104408.63	
GRAND TOTAL:						203909636.15
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8365.52
Average Length of Stay on the Waiver:						299

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 month	4123	8.27	32.39		
Specialized Medical Equipment and Supplies Total:						18024321.93
Specialized Medical Equipment and Supplies	1 item	17916	940.23	1.07	18024321.93	
Therapy Services Total:						692.48
Physical Therapy	15 minutes	1	16.00	21.64	346.24	
Occupational Therapy	15 minutes	1	16.00	21.64	346.24	
GRAND TOTAL:						203909636.15
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8365.52
Average Length of Stay on the Waiver:						299

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2150041.45
Adult Day Health (ADH)	15 minutes	355	2730.40	2.21	2142135.32	
Therapy in ADH	1 Session	1	24.00	12.42	298.08	
Personal Care in ADH	1 Session	19	45.11	8.78	7525.25	
Laundry in Adult Day Health	1 Session	1	10.00	8.28	82.80	
Case Management Total:						52081294.45
Case Management	15 minutes	20007	121.99	16.23	39611813.28	
Very Rural Case Management	15 minutes	4368	122.89	23.23	12469481.17	
Personal Care Total:						75612676.57
GRAND TOTAL:						212467882.76
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8716.63
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care	15 minutes	17592	961.55	4.47	75612676.57	
Respite Total:						376079.35
In-Home Respite	15 minutes	97	388.93	4.47	168636.16	
Extended In-Home Respite	1 Day	2	14.00	186.30	5216.40	
Nursing Facility Respite	1 Day	63	17.23	186.30	202226.79	
Extended State Plan Skilled Nursing Total:						3589.06
Registered Nurse Extended State Plan Skilled Nursing	15 minutes	3	59.84	16.55	2971.06	
Licensed Practical Nurse Extended State Plan Skilled Nursing	15 minutes	2	20.00	15.45	618.00	
Prescribed Drugs Total:						4169125.49
Prescribed Drugs	1 each	2533	20.30	81.08	4169125.49	
Advanced Supportive/Restorative Assistance Total:						966415.68
Advanced Supportive/Restorative Assistance	15 minutes	305	660.12	4.80	966415.68	
Assisted Living Services Total:						13356160.17
Tier Two	1 Day	225	165.63	70.16	2614635.18	
Tier Three	1 Day	592	146.57	98.13	8514685.15	
Tier One	1 Day	228	187.86	51.99	2226839.84	
Consumer-Directed Personal Assistance Supports and Services Total:						13383536.29
Personal Services Assistance (PSA)	15 minutes	1563	2003.32	3.78	11835895.02	
Goods & Services	1 item	1042	228.73	1.10	262170.33	
Advanced PSA	15 minutes	247	1148.86	4.53	1285470.94	
Environmental Accessibility Modifications Total:						639036.00
Environmental Accessibility Modifications	1 project	90	1.00	7100.40	639036.00	
GRAND TOTAL:						212467882.76
<i>Total Estimated Unduplicated Participants:</i>						24375
<i>Factor D (Divide total by number of participants):</i>						8716.63
<i>Average Length of Stay on the Waiver:</i>						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home-Delivered Meals Total:						24844072.17
Home-Delivered Meals	1 Meal	16363	277.57	5.47	24844072.17	
Hospice Care Total:						511767.14
Hospice Care	1 Day	52	74.91	131.38	511767.14	
Institution Transition Services Total:						29978.32
Transitional Case Management	15 minutes	50	6.59	16.23	5347.78	
Very Rural Transitional Case Management	15 minutes	189	5.61	23.23	24630.54	
Nursing Total:						4422055.12
Nursing Assessment / Evaluation	15 minutes	20654	8.91	16.55	3045649.17	
Registered Nurse Skilled Nursing	15 minutes	1107	32.83	16.55	601473.51	
Licensed Practical Nurse Skilled Nursing	15 minutes	872	57.52	15.45	774932.45	
Personal Emergency Response Systems Total:						1193227.56
PERS Installation	1 year	885	1.00	50.00	44250.00	
PERS Monthly	1 month	4205	8.27	33.04	1148977.56	
Specialized Medical Equipment and Supplies Total:						18728121.69
Specialized Medical Equipment and Supplies	1 item	18274	940.23	1.09	18728121.69	
Therapy Services Total:						706.24
Physical Therapy	15 minutes	1	16.00	22.07	353.12	
Occupational Therapy	15 minutes	1	16.00	22.07	353.12	
GRAND TOTAL:						212467882.76
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						8716.63
Average Length of Stay on the Waiver:						299

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be

completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2231970.00
Adult Day Health (ADH)	15 minutes	362	2730.40	2.25	2223910.80	
Therapy in ADH	1 Session	1	24.00	12.66	303.84	
Personal Care in ADH	1 Session	19	45.11	8.95	7670.96	
Laundry in Adult Day Health	1 Session	1	10.00	8.44	84.40	
Case Management Total:						53109224.13
Case Management	15 minutes	20007	121.99	16.55	40392822.54	
Very Rural Case Management	15 minutes	4368	122.89	23.69	12716401.59	
Personal Care Total:						78678482.59
Personal Care	15 minutes	17944	961.55	4.56	78678482.59	
Respite Total:						390437.97
In-Home Respite	15 minutes	99	388.93	4.56	175578.56	
Extended In-Home Respite	1 Day	2	14.00	190.02	5320.56	
Nursing Facility Respite	1 Day	64	17.23	190.02	209538.85	
Extended State Plan Skilled Nursing Total:						3662.49
Registered Nurse Extended State Plan Skilled Nursing	15 minutes	3	59.84	16.89	3032.09	
Licensed Practical Nurse Extended State Plan Skilled Nursing	15 minutes	2	20.00	15.76	630.40	
Prescribed Drugs Total:						4338045.04
Prescribed Drugs	1 each	2584	20.30	82.70	4338045.04	
Advanced Supportive/Restorative Assistance Total:						1003903.89
Advanced Supportive/Restorative Assistance	15 minutes	311	660.12	4.89	1003903.89	
Assisted Living Services Total:						15395140.29
GRAND TOTAL:						221388727.29
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						9082.61
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Tier Two	1 Day	254	165.63	71.56	3010530.63	
Tier Three	1 Day	669	146.57	100.09	9814357.98	
Tier One	1 Day	258	187.86	53.03	2570251.68	
Consumer-Directed Personal Assistance Supports and Services Total:						13906471.46
Personal Services Assistance (PSA)	15 minutes	1594	2003.32	3.85	12294174.51	
Goods & Services	1 item	1063	228.73	1.13	274748.19	
Advanced PSA	15 minutes	252	1148.86	4.62	1337548.77	
Environmental Accessibility Modifications Total:						666300.80
Environmental Accessibility Modifications	1 project	92	1.00	7242.40	666300.80	
Home-Delivered Meals Total:						25803823.18
Home-Delivered Meals	1 Meal	16690	277.57	5.57	25803823.18	
Hospice Care Total:						532050.52
Hospice Care	1 Day	53	74.91	134.01	532050.52	
Institution Transition Services Total:						31212.16
Transitional Case Management	15 minutes	51	6.59	16.55	5562.29	
Very Rural Transitional Case Management	15 minutes	193	5.61	23.69	25649.87	
Nursing Total:						4603198.28
Nursing Assessment / Evaluation	15 minutes	21067	8.91	16.89	3170370.72	
Registered Nurse Skilled Nursing	15 minutes	1129	32.83	16.89	626029.03	
Licensed Practical Nurse Skilled Nursing	15 minutes	890	57.52	15.76	806798.53	
Personal Emergency Response Systems Total:						1241393.01
PERS Installation	1 year	903	1.00	51.00	46053.00	
PERS Monthly					1195340.01	
GRAND TOTAL:						221388727.29
Total Estimated Unduplicated Participants:						24375
Factor D (Divide total by number of participants):						9082.61
Average Length of Stay on the Waiver:						299

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	1 month	4289	8.27	33.70		
Specialized Medical Equipment and Supplies Total:						19452691.14
Specialized Medical Equipment and Supplies	1 item	18639	940.23	1.11	19452691.14	
Therapy Services Total:						720.32
Physical Therapy	15 minutes	1	16.00	22.51	360.16	
Occupational Therapy	15 minutes	1	16.00	22.51	360.16	
GRAND TOTAL:					221388727.29	
<i>Total Estimated Unduplicated Participants:</i>					24375	
<i>Factor D (Divide total by number of participants):</i>					9082.61	
<i>Average Length of Stay on the Waiver:</i>					299	