



Priority Evaluation of the Oklahoma Department of Human Services Developmental Disabilities Services Waiver Waiting List

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The 1999 U.S. Supreme Court Olmstead decision established that those with needs meeting an institutional level of care have the right to receive services within their community, if able.

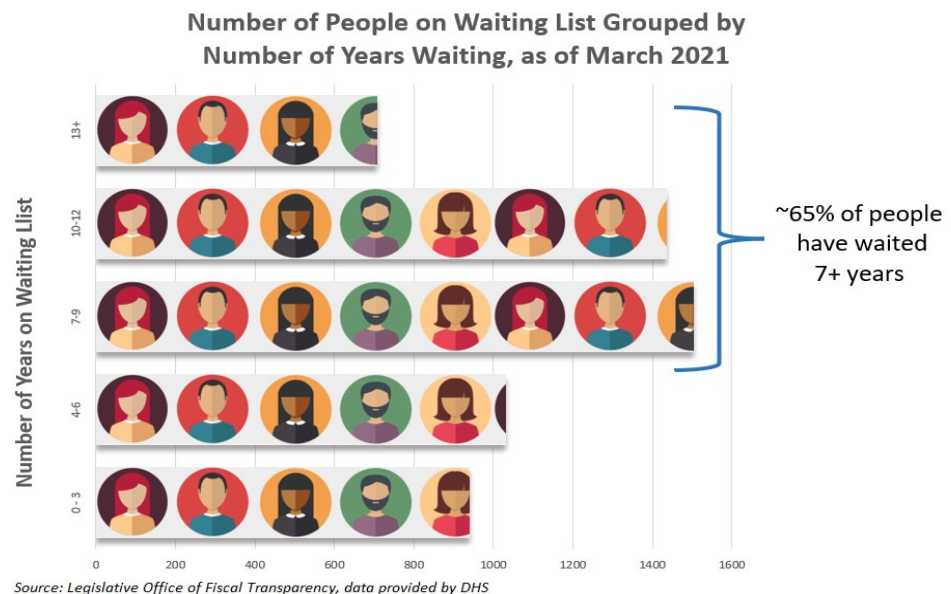
Home Based Community Waivers are a tool for states to comply with the Olmstead decision by providing those with disabilities access to in-home and community-based services instead of institutional-based services.

Executive Summary

Prior to 1981, individuals with critical developmental or intellectual disabilities were often limited to receiving state-funded support in an institutional setting. Expansion of the Social Security Act provided guidelines to states for meeting those needs outside of institutional care.

Through Home and Community-Based Services Waivers, states have the option of “waiving” certain Medicaid program requirements to tailor services to Medicaid recipients living in their communities. Federal guidelines provide states with broad authority in creating waiver programs, as long as the cost of services provided through the waiver don’t exceed the costs of services in an institutional setting.

When state resources and funding are not available to meet the needs of all those who seek services provided through Medicaid waivers, a “waiting list” is created. There are 5,619 physically or mentally disabled Oklahomans waiting to receive services through a state waiver as of March 2021.



Oklahoma offers six different Home and Community-Based Services Waivers. This evaluation examines only the waivers for which there is a waiting list for services. Each of the three programs with waiting lists are administered by the Department of Human Services:

- The Community Waiver
- The In-Home Services Waiver, Child
- The In-Home Services Waiver, Adult

Through this evaluation, the Legislative Office of Fiscal Transparency (LOFT) examined past and current efforts to transition more people from waiting for services to receiving services through Home and Community-Based Services Waivers and sought to identify both opportunities and resources needed to better meet the needs of those waiting.

LOFT's evaluation resulted in three key findings:

Finding 1: DHS' Management of the Waiver Program Has Not Led to Substantial Progress Toward the State's Goal of Providing Services to All Those Waiting

The two key drivers of waiting lists are high demand and program limitations, which can include a program's structural design or resources. LOFT found that the number of people moved from Oklahoma's Waiting List into waiver services over the past decade has remained relatively flat, despite the Oklahoma Legislature dedicating almost \$9 million over the past eight years to the Department of Human Services (DHS) for this purpose. LOFT observed no direct correlation between the additional appropriated funds and the actual transition of people moving from the Waiting List into a waiver.

The greatest change in the Waiting List – 2,400 applicants removed in 2019 – was due to purging the names of those who could not be reached or no longer needed services. In evaluating past and current management of the waiver program, LOFT found that DHS's failure to determine eligibility upon intake of those signing up on the Waiting List limits the agency's understanding of individuals' needs and subsequently, development of a plan to meet them. Proper intake could also determine which of those waiting need immediate services and which are waiting in anticipation of future service needs.¹

DHS recently contracted for an independent assessment of the needs of those waiting for waivers; the sixth assessment to be conducted in approximately a decade. LOFT did not observe key differences in the type of data collected between the current and past assessments, nor a strategic plan for how this new information would be used to move those waiting into waivers.

Approximately half of those on the Waiting List contacted by DHS for services are not moved into waiver services. LOFT found that DHS' management of the Waiver Program and lack of case management upon application for a waiver are contributing to inflation of the Waiting List.

Currently, DHS is processing waiver applications for people who signed up on the list 13 years ago. Under these conditions, a 5-year-old entering the Waiting List today would likely never receive the In-Home Service Waivers for Children due to the length of the wait time. That child would age out before becoming eligible and would first receive services under the more expensive In-Home, Adult or Community Waivers.

¹ [Social Security Act, Section 1915 \(E\) Independent Assessment through \(G\) Individualized Care Plan](#)

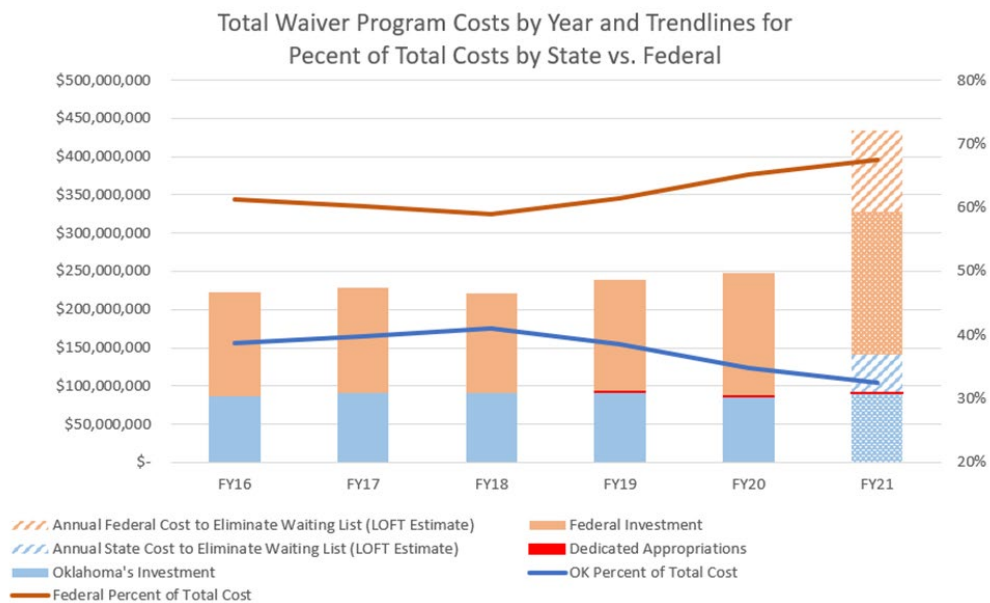
Finding 2: The Ratio of Budgeted Community-Based and In-Home Services Waiver Slots to Members Served is Declining, Despite Increases in State and Federal Funding

States that offer waiver programs submit a plan to the Federal government demonstrating its ability to continually fund any wavier slots. In comparing the number of members served from FY16 to FY20 to the number of waiver slots budgeted for in the agency's five-year plan, LOFT found that DHS is serving less members than its plan states it can serve. Additionally, LOFT observed a declining percentage of members served over the five-year period when compared to the number of slots budgeted for in the agency's plan.

The In-Home Services Waiver for Children, which is only available for children aged 3-17, has the lowest utilization rate (or service rate) of all DHS's Home and Community-Based Services Waivers. This waiver is currently the most cost-effective Medicaid waiver offered in Oklahoma, yet DHS offers a maximum of 250 waiver slots for this program and for the past three years has served just over half of those slots. 1,890 of those on the Waiting List are between the ages of 3-17.

The Developmental Disabilities Services division (DDS), which administers the Home and Community-Based Waiver Program, is one of seventeen divisions within DHS. LOFT found that increases in Federal matching funds, State appropriations, and an overall increased budget to DHS, have not resulted in serving substantially more people through the Community and In-Home Services Waiver Program.

This chart shows the Federal and State investment into the DDS Waiver Program for Community and In-Home Services from FY16 to FY21. This depicts a growing federal investment from FY18 to



Source: Chart by Legislative Office of Fiscal Transparency, program cost data from OHCA

FY21, requiring less state investment to maximize program outcomes. Currently, Oklahoma receives an approximate 3:1 Federal match. The bar for FY21 shows LOFT's calculation for the investment required to serve all members of the Waiting List, using the blended Federal Medical Assistance Percentage (FMAP).

Key Facts:

The Oklahoma Health Care Authority has oversight over all Medicaid waiver programs.

Through an interagency agreement, the Department of Human Services has authority to direct operations or make programmatic changes to the Waiver Program.

Oklahoma is just one of six states that have a state agency other than the state's Medicaid agency operating the waiver program.

DHS contends its ability to operate the Community and In-Home Services Waivers has been limited by the number of available providers, low provider rates, antiquated technology, and regulatory restrictions. LOFT observed no correlation between the number of Medicaid providers and the number of members being served, a metric that must be determined before DHS submits its five-year plan for each waiver to the Federal government. Additionally, LOFT identified various mechanisms available to the State to stabilize or increase provider rates, if needed. While DHS' technology is outdated, LOFT found it to have robust capabilities that could be enhanced with knowledge investments. Last, LOFT found no basis for DHS' claims of existing rules limiting the agency's ability to assess the needs of those applying for a waiver, a fact affirmed by the third-party assessment currently underway.

Finding 3: There Are Both Immediate and Long-Term Opportunities to Increase the Number of People Served by Community and Home-Based Services Waivers

LOFT took three approaches to determining what resources would be required to serve all those currently on the Waiting List:

Scenario 1: \$16 million in State funds. This scenario assumes no changes to the program or Waiting List, and that 55 percent of people waiting will be determined eligible for services.

Scenario 2: No additional investment, but strategically maximize current funds. With this scenario, LOFT estimated the impact of amending the number of waiver slots allocated to different programs. DDS plans to add 66 waiver slots to the Community Waiver in FY23. LOFT found this waiver is not currently serving all member slots budgeted to it. By limiting the current Community Waiver capacity increase to 16 instead of 66 and reallocating the associated budgeted costs to the In-Home waiver, Oklahoma could serve 693 additional children or 346 adults by FY23, at no additional cost.

Scenario 3: \$5 million strategic investment into just the waiver serving children ages 3-17. If the State were to shift from a "first on, first off" processing of all waivers and instead chronologically serve those within respective waiver groups, it could target funds to a specific waiver for strategic impact. LOFT estimates 1,890 children could be served with a \$5 million investment; the entire child demographic on the Waiting List.

Both State and Medicaid rules provide Oklahoma the flexibility to change its waiver program, and processes exist to amend service plans. Changes could take effect within 6-9 months.

Summary of Policy Considerations and Agency Recommendations

Policy Considerations

The Legislature may consider the following:

- For improved transparency, repurpose an existing fund or create a program stabilization fund. Identified unutilized funds or realized programs savings could be deposited for targeted reinvestments.
- Requiring a more transparent process to establish provider incentive payments, with an emphasis on paying incentives based on performance or metrics the state wishes to achieve, such as adding specific vendors to allow for higher utilization of waivers.
- Requiring annual updates be provided to the Legislature regarding a strategic plan to increase the number of people served from the Community and In-Home Services Waiver Program Waiting List. Updates should reflect progress made toward milestone objectives.
- Requiring publicly available monthly data updates reflecting current cost expenditures and number of waivers being utilized by month and year to date.
- Dedicating funds for a third-party operational audit to identify inefficiencies and duplication of services within the Developmental Disabilities Services division and its partners, which could create internal savings to be reinvested into the program.
- Requiring that data collected by Liberty Healthcare of Oklahoma (Liberty) and reported to the Department of Human Services be made publicly available online and updated regularly to provide, at minimum, the number of people on the Waiting List.

Agency Recommendations

DHS should:

- Create a strategic plan with goals and milestone objectives for how the Developmental Disabilities Services Waiver Program will be enhanced. Goals should be fully achievable two years before the State's renewal deadline for the current program.
- Conduct a cost analysis of its waiver structure to identify opportunities for adding or adjusting waiver services to improve cost effectiveness and to enable more people to be moved onto waivers.
- Revise management of the Waiting List so that only those who need immediate services are shown on the public-facing Waiting List. The agency should maintain a separate list of those who anticipate needs in the future.
- Make the data reporting required in the Liberty contract publicly available, including data on the cost of the waiver program and the number of waivers being utilized.
- Enhance communications with the people on the Waiting List, including communication of any program changes and potential impact, as well as estimates for wait times.
- Deposit any one-time funds, such as service costs of an individual plan being less than budgeted, or other cost savings generated through the program, into the program stabilization fund. Funds should be reinvested into the programs to achieve goals listed within a strategic plan.

Key Questions:

- What resources would it take to serve those on the waiting list right now?
- What efforts have been made to try serve those on the waiting list?
- What are the current characteristics and needs of those on the waiting list?
- How can the state better serve those who are waiting?
- Are there any additional resources or funding streams that could be used to support families on the waiting list while they are waiting?
- Do other states have waiting lists? If so, what states and how do they manage those lists?

Introduction

Home and Community Based Waivers

In 1981, through the Omnibus Budget Reconciliation Act, the Social Security Act (SSA) was expanded to include guidelines for states to meet the needs of physically or mentally disabled people outside of an institutional setting. Those served include individuals with autism, brain injuries, cerebral palsy, Down Syndrome, intellectual disabilities, and others who meet the level of care eligibility requirements for services in an institutional setting.

The Home and Community-Based Services Waivers (HCBS) gives states the option to waive certain Medicaid program requirements to tailor services to Medicaid recipients living in their communities, as opposed to institutions. Today, through Section 1915 of the SSA, there are several waiver programs that allow alternatives to institutional care.²

States have broad authority to create waiver programs for specific groups.³ States have the flexibility to target services by age, condition, or location, among other member needs, as long as the cost of services provided through the waiver don't exceed the costs of institution-based services, and the health and welfare of people are at the center of any plan. States also determine the maximum number of people that will be served by a waiver. In 2005, HCBS services became a formal Medicaid State Plan option. Forty-seven states and the District of Columbia operate at least one HCBS waiver.⁴

Oklahoma offers six different 1915 (c) HCBS waivers. Five are administered by the Oklahoma Department of Human Services (DHS) and one by the Oklahoma Health Care Authority (OHCA).

For this evaluation, LOFT examined only the waivers for which there is a waiting list for services. Each of the three programs with waiting lists are administered by DHS and include:

- The Community Waiver
- The In-Home Services Waiver, Child
- The In-Home Services Waiver, Adult

² [Home & Community Based Services \(HCBS\), Medicaid](#)

³ Ibid

⁴ [Home & Community Based Services Authorities | Medicaid](#)

Table 01: This table reflects the current Home & Community Based Services 1915 (c) waivers offered in Oklahoma. The Operating Entity is the agency responsible for the strategic planning of the waiver and the administrative day-to-day tasks.

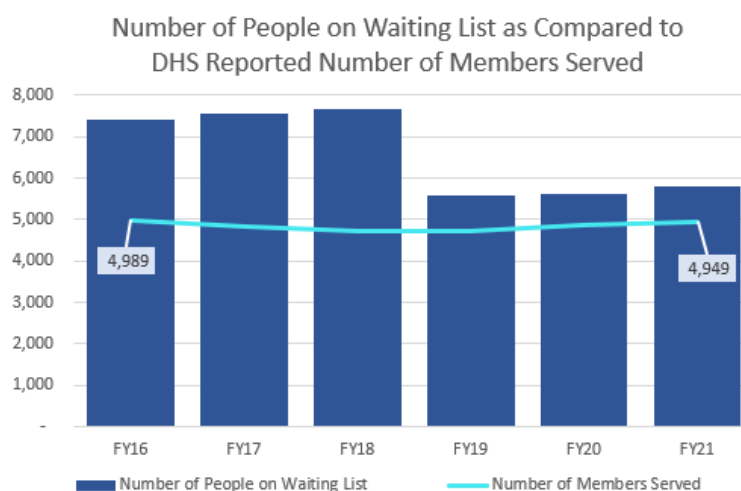
Operating Entity	Waiver	State Eligibility Requirements
Waivers Evaluated for this Report		
DHS	Community	<i>Only for those individuals who have critical support needs that cannot be met by the In-Home Supports Waiver (IHSW) or other alternatives. If this is the case, you can make a request to DDS to be moved to the Community Waiver. Otherwise, the eligibility requirements are the same as the In-Home Supports Waiver.</i>
DHS	In-Home, Child & In-Home, Adult	<p><i>The individual must: have an IQ below 70 and functional limitations in three or more of the following areas: self-care, communication, learning, mobility, self-direction, independent living, and economic self-sufficiency. The individual also must:</i></p> <ul style="list-style-type: none"> <i>• Be age 3 or older. (The adult waiver begins at age 18.)</i> <i>• Meet ICF-IDD level of care criteria</i> <i>• Not have an individual income (family income not counted) exceeding 300% of allowable Social Security Income and no more than \$2,000 in resources.</i> <i>• Live in his or her own home, the home of a family member or friend, a DHS group home, or a DHS foster home.</i> <i>• Be a resident of the state of Oklahoma</i>
Waivers Not Evaluated for this Report		
DHS	Homeward Bound	<i>Financially eligible for Medicaid, have a diagnosed intellectual disability, need institutional level of care, and meet other waiver-specific criteria</i>
OHCA	Medically Fragile	<i>Persons meeting institutional level of care requirements and have a chronic physical condition that leaves them dependent on medical technology.</i>
DHS	Advantage	<ul style="list-style-type: none"> <i>• Be age 65 or older, or be age 21-64 with physical or developmental disabilities that do not include an intellectual disability.</i> <i>• Be SoonerCare (Medicaid) eligible.</i> <i>• Meet nursing facility level of care criteria (see page 25).</i> <i>• Meet Medicare financial standards for long-term care services.</i> <i>• Reside in the home (cannot be living in an institution, room and board facility, or nursing home)</i>

Source: Legislative Office of Fiscal Transparency, University of Oklahoma Health & Science Center, DHS

Finding 1: DHS' Management of the Waiver Program Has Not Led to Substantial Progress Toward the State's Goal of Providing Services to All Those Waiting

When state resources and funding are not available to meet the needs of all those who seek services provided through Medicaid waivers, a “waiting list” is created. There are two key drivers to waiting lists: high demand, and program limitations. There are 5,619 developmentally disabled Oklahomans waiting to receive services through a state waiver as of March 2021.⁵

Chart 01: Number of People Waiting for Waiver Services and Number of Members being Served. This chart displays the number of persons waiting annually as of July each State Fiscal Year for the past eight fiscal years. The numbers reflect only those served under the three waivers examined in this report. The drop in number from 2018 to 2019 is due to list cleanup and not reflective of Community or In-Home Services waivers provided.



Source: Legislative Office of Fiscal Transparency, data gathered from DHS annual reports & OHCA Members Served

For more than a decade, Oklahoma's Waiting List has numbered in the thousands, peaking in FY18 at more than 7,600 people waiting for services. While the number of people waiting has declined, the largest reduction has been attributable to causes unrelated to providing services. For example, in FY19 the Department of Human Services (DHS) conducted a list “clean-up,” which included contacting persons waiting for services to verify whether services were still needed.⁶ This resulted in 2,400 applicants being removed from the Waiting List for reasons that included the person asking to be removed, a failure to reach the person waiting, the death of the applicant, or the applicant no longer living within the State. DHS does not track longitudinal data associated with these Waiting List changes prior to FY19 and only captures broad categories for why someone might have been removed from the waiting list without receiving services.⁷

⁵ [Key State Policy Choices About Medicaid Home and Community-Based Services \(kff.org\)](https://www.kff.org/medicaid/state-policy-choices-about-medicicaid-home-and-community-based-services/)

⁶ DHS responses to LOFT questions

⁷ Ibid.

Recent Actions

In an effort to reduce the number of people waiting to receive services, for the past three years the Legislature has dedicated approximately \$2 million annually in additional funds for “additional services and programs” to those on the Waiting List.⁸ Between FY19 and FY21, \$5.92 million in additional appropriations was provided to the DHS to serve persons on the Waiting List.

As detailed in the sidebar (right), the Legislature has taken action to increase the resources available to DHS for serving more of those waiting to receive waivers. However, as shown in Chart 01 on page 3, the level of people being served by waivers has remained relatively flat over time, increasing from 4,430 in FY13 to 4,769 in FY20. As explained above, the significant decline from FY18 to FY19 was attributable to DHS reconciling records to remove the names of those who could not be contacted, no longer needed services, did not qualify, or otherwise could be removed from the Waiting List, as determined by DHS.

LOFT observed no direct correlation between the additional appropriated funds dedicated for serving those waiting and the actual transition of people moving from the Waiting List to receiving a waiver. The lack of impact is largely attributable to two programmatic limitations:

First, the State cannot set the maximum level of waivers beyond what it is able to demonstrate it has funds to support within the current plan.^{9 10} **In short, the State cannot agree to provide a waiver unless it can also ensure continuation of the waiver, providing stability for the people in need of services.**

Second, the state is bound to the five-year figures it forecasts to the Federal government regarding the maximum number of waivers it is able to serve. However, the State can amend its plan at any time by submitting new figures to the Center for Medicare and Medicaid Services (CMS), a process that typically takes between six to nine months.¹¹

The Oklahoma Legislature has dedicated almost \$9 million over the past eight years to the Oklahoma Department of Human Services (DHS) for the purpose of providing waiver services to those waiting.

Additional Dedicated Appropriations:

FY13 - \$1M
FY14 - \$1M
FY15 - \$1M
FY19 - \$2M
FY20 - \$2M
FY21 - \$1.92M

Total: \$8.92M

⁸ Per statutory language provided in SB1932 (2020 session), SB1055 (2019 session), and HB 3708 (2018 session)

⁹ Defined by the Social Security Act, part 1915 (c) and Medicaid rules

¹⁰ Social Security Act, Section 1915 (c), described further in Finding 2

¹¹ Estimate provided by OHCA

A Lack of Understanding About the Needs of Those Waiting

Assessments are a strategic tool states use to obtain information about the population seeking services and often are the basis for developing a service plan. Typical data points of assessments include an individual's living arrangements, current level of support being received, whether the applicant needs help in understanding the services available and what they qualify for, whether childcare would enable a family member to work, and – if known – the services most needed. Assessments can be conducted periodically, as Oklahoma has done, or can be conducted continuously through case management.

As reflected in Figure 01 on page 6, five assessments of the Waiting List have been conducted in the previous ten years to gather information about the demographics and needs of those waiting, as well as examining other states' best practices. A sixth assessment was initiated in 2021 when DHS executed a contract with Liberty Healthcare of Oklahoma (Liberty). Initial data from this assessment is expected in January of 2022.

LOFT's analysis of Liberty's contract with DHS found that the type of data being collected by the current assessment is not materially different than prior assessments, although it is more in-depth and includes a larger sample size. In examining the current contract's statement of work, one key difference from prior assessments is that Liberty will convert the information from the assessment into a dashboard containing demographic information of those on the Waiting List. **However, the contract does not stipulate how the information will be used to provide better service to those on the Waiting List nor does the contract stipulate how information will be used to move those waiting into Waivers.**

Table 2: This table depicts components of past and current assessments. While prior assessments rely on samples, Liberty's assessment is required to be comprehensive under new CMS rules.

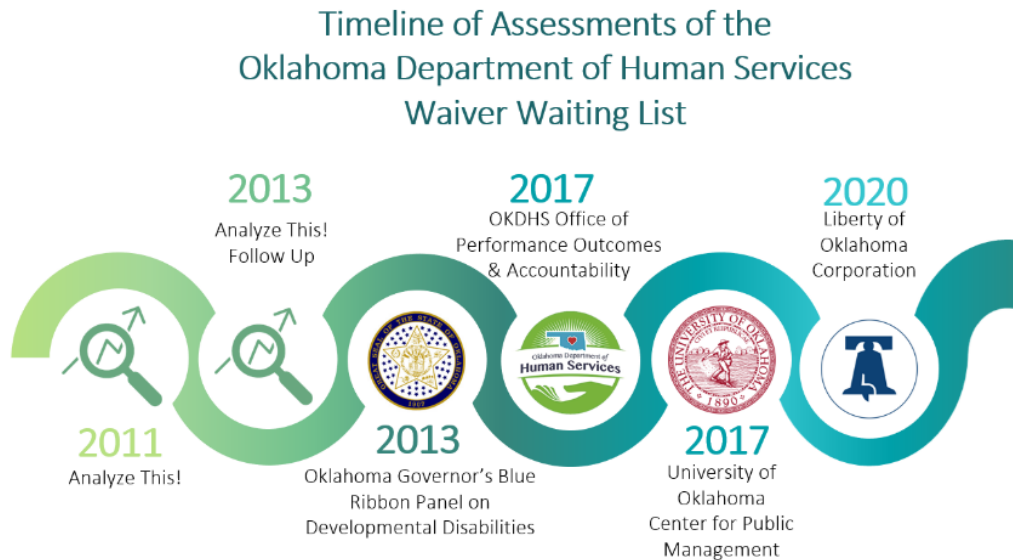
Liberty of Oklahoma, Statement of Work	Type of Service Covered by Assessment/ Contract	Covered by Prior Assessment
Implement Standardized Assessment Tool & Case Management System	Waiting List Management	2011 2013 2015 2017 (DHS) 2017 (OU)
Utilize Tools to Assess Future Needs		
Navigation Assistance to Service While Waiting	Case Management Functions	2011 2013 2015 2017 (DHS)
Serve as Single Point of Contact for HCBS Waivers and Services		
Wait List Management Strategies		
Tailor Assessment Information to Individual Needs		
Services Outside of HCBS Waivers		
Application Process for Services		
Follow For Support		
Outreach and Support to Families		
Connect Resources		
Eligibility Requirements for Waitlist	Database Management	2011 2013 2015 2017 (OU)
Weekly Analysis		
Ad Hoc Reporting		
Reporting Requirements		
Quality Assurance		

Source: Legislative Office of Fiscal Transparency

As of the date of this report, LOFT has not been provided with any strategic plan from DHS explaining how the Liberty assessment and partnership will achieve the stated goal of eliminating the Waiting List.

Table 02, on page 5, summarizes the statement of work of the Liberty contract compared to the deliverables of prior assessments. This table illustrates what services DHS is requiring Liberty provide during the duration of the contract. Liberty's comprehensive assessment will bring DHS into compliance with the CMS' HCBS Final Rule 2014, which states are required to implement by March 2022.¹² Many of the functions provided by the assessment, primarily case management, are core duties of staff positions within DHS.¹³ Prior assessments were united in recommending that DHS conduct better case management. According to DHS, there are currently 262 case managers within its Developmental Disabilities Services (DDS) division. Through the Liberty contract, the agency is outsourcing this function.¹⁴

Figure 01: Timeline of past assessments of the Waiting List, including the current assessment by Liberty Healthcare of Oklahoma.



Source: Legislative Office of Fiscal Transparency

¹² See Page 17 of this report for further detail on CMS HCBS Final Rule 2014.

¹³ See Appendix I for description of duties for a DDS Case Manager III

¹⁴ As relayed to LOFT by DHS personnel on July 8th, 2021.

Key Characteristics of People on the Waiting List

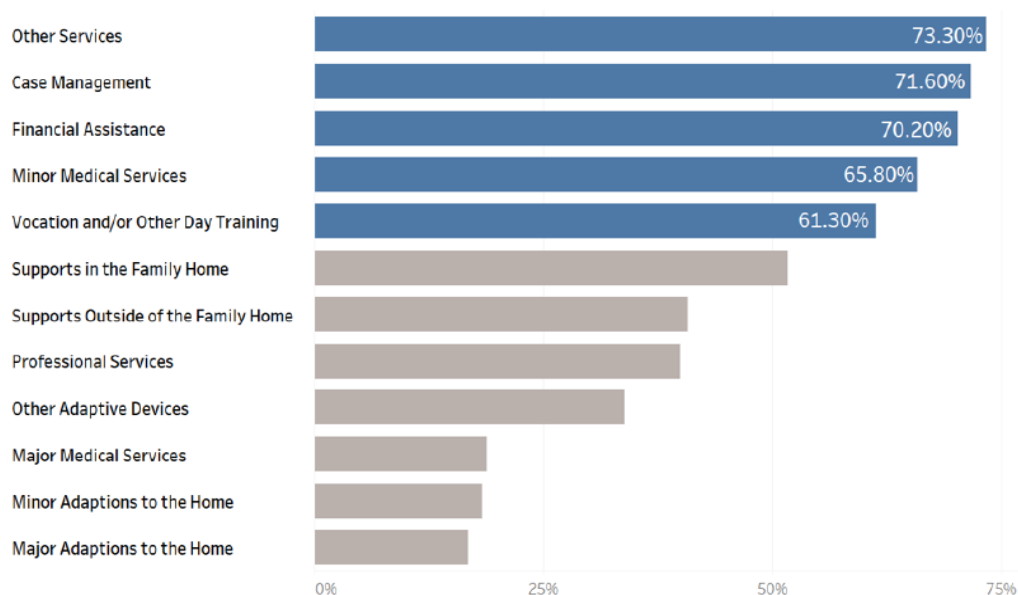
Prior assessments of those on the Waiting List have provided the following information about those waiting to receive services:

Figure 02: Income Range for the People on the Waiting List. This table shows the income range for people on the waiting list. In 2013, 94% of applicants over the age of 18 had an income of less than \$29,999. Source: 2013 Blue Ribbon Panel Assessment.

Income	Applicants Under 18 Years		Applicants 18 Years or Older	
	#	%	#	%
Under \$15,000	69	32%	163	90%
\$15,000 - \$29,999	41	19%	7	4%
\$30,000 - \$44,999	46	21%	1	1%
\$45,000 - \$59,999	18	8%	1	1%
\$60,000 - \$74,999	9	4%	0	0%
\$75,000 - \$89,999	3	1%	0	0%
Over \$89,999	11	5%	0	0%
I don't know/Choose not to share	19	9%	10	5%

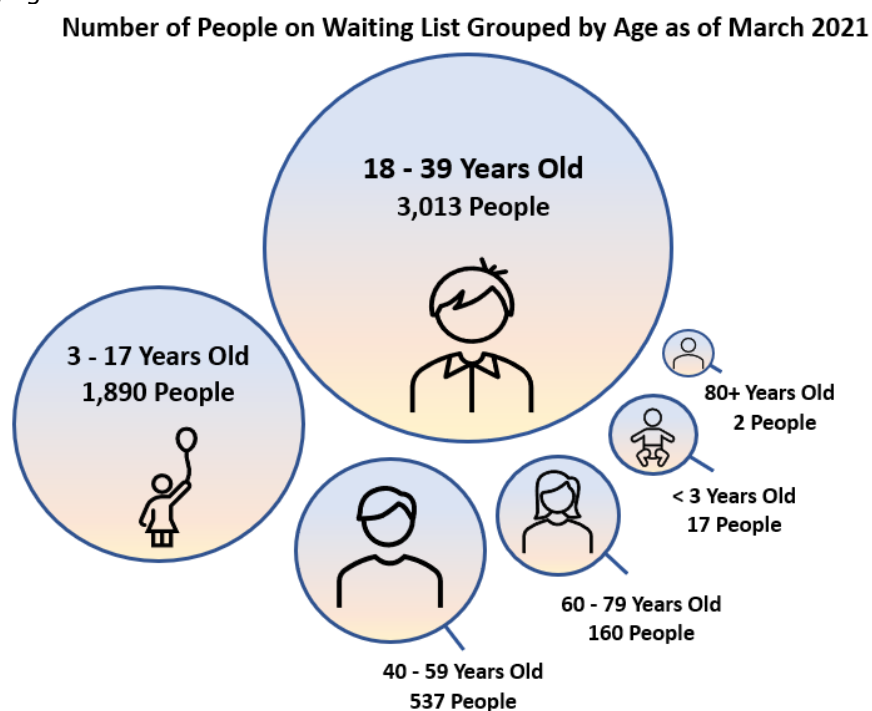
Chart 02, below, depicts information from the 2013 assessment reflecting that more than 60% of respondents wanted vocational and other day training, which includes life skills that support maintaining employment. 73% of respondents wanted other services, which include personal care services.

Chart 02: Services Most Requested Services by Age Group for those on the Waiting List.



Source: Legislative Office of Fiscal Transparency's recreation of Analyze This! 2013 data

Figure 03: Infographic showing number of people currently on the waiver Waiting List by age group. As of March 2021, 33.6 percent of the people on the Waiting List are between 3-17 years of age.



Source: Legislative Office of Fiscal Transparency, data provided by DHS

Eliminating the waiting list is not as straightforward as it may seem. As noted in a 2017 news article about a state panel's recommendation to revise the Waiting List, not all families waiting know what services they need or when they will need them. As reported:

*"Ann Trudgeon, executive director of the Developmental Disabilities Council, said advocates like herself bear some responsibility for the length of the list. "I feel like parents would come to us and say, 'I have child with a disability,' and the first thing we'd do is say, 'Get on the waiting list,'" she said."*¹⁵

The Waiting List may be overstated because it includes people who do not immediately need services but have registered in anticipation of services that will be needed in the future. The existence of the Waiting List, and the long wait times associated with it, have led people to join the Waiting List before they need services or as an insurance measure if they cannot get their needs met elsewhere. DHS reports that approximately half of individuals contacted for services are not moved from the Waiting List into receiving services. People on the Waiting List may even decline services but choose to remain on the Waiting List in the event they need services in the future.

Figure 03 depicts the number of people on the Waiting List, grouped by age. Approximately 33.6 percent of the people on the Waiting List are between ages 3-17.¹⁶ The In-Home Services

¹⁵ Mollie Bryant, "Will State's Makeover of Developmental Disabilities Wait List Be Fair to Families?," [Oklahoma Watch, July 26, 2017](#).

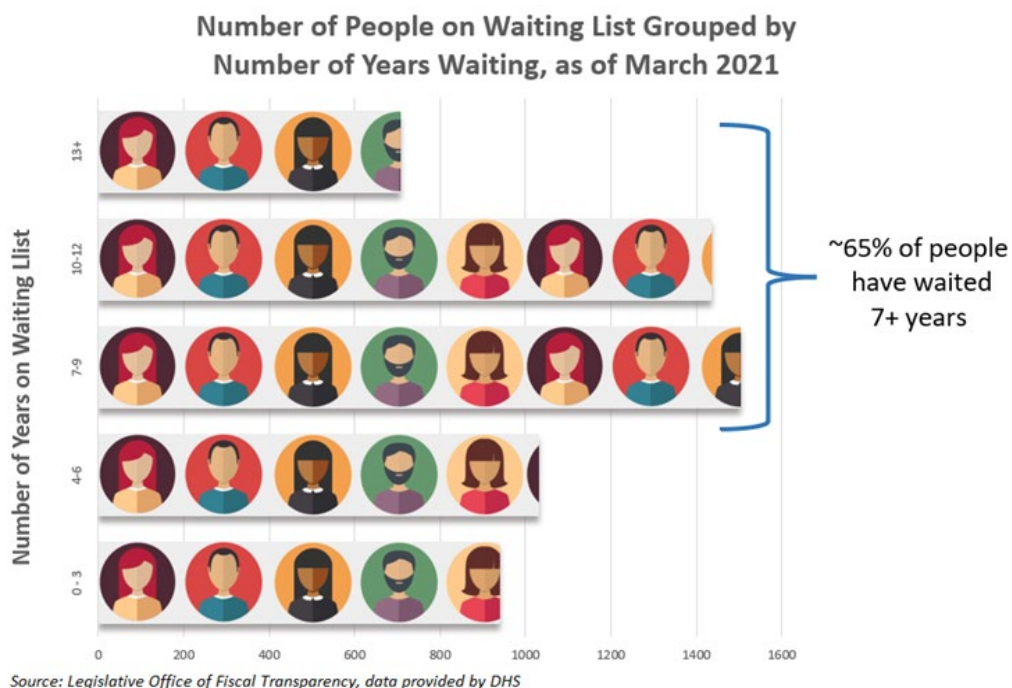
¹⁶ There are 17 Children aged 0-3 on the Waiting List, an age group that cannot be served by Medicaid Waivers

Waivers for Children, which is only available for children aged 3-17, is the most cost-effective Medicaid waiver offered in Oklahoma at this time. This is due to many of the services needed by this age group being covered under the State's Medicaid Plan, such as SoonerCare.

The DHS Waiver Program currently offers 250 In-Home Services Waiver slots for the 3-17 age group. Data from DHS shows there are 1,890 people between 3-17 years of age on the Waiting List. **Currently, the agency is processing waiver applications for people who signed up on the list 13 years ago.**¹⁷ Under these conditions, a 5-year-old entering the Waiting List today would likely never receive the In-Home Services Waivers for Children due to the length of the wait time. That child would age out before becoming eligible and would first receive services under the more expensive In-Home, Adult or Community Waivers. The fact that there are so many children waiting for services is not due just to the limited availability of waivers; there are 116 budgeted but unfilled waiver slots for this group. This information is detailed in Finding 2.

LOFT was unable to quantify the cost of deferring care to children waiting for services, however, early childhood intervention has been found beneficial for children with developmental disabilities, as well as their caregivers. Notably, intervention has been shown to increase the likelihood of maximizing developmental potential, quality of life, social participation, as well as positive mental health impacts and greater community support.^{18 19 20}

Chart 03: This chart shows the number of people on the Waiting List grouped by years on the Waiting List. Approximately 65 percent of people have been waiting 7+ years.



¹⁷ As relayed to LOFT by DHS personnel on July 8, 2021.

¹⁸ Collins PY, Pringle B, Alexander C et al. Global services and support for children with developmental delays and disabilities: bridging research and policy gaps. PLoS Med. 2017 ;14(9):e1002393.

¹⁹ Scherzer AL, Chhagan M, Kauchali S, et al. Global perspective on early diagnosis and intervention for children with developmental delays and disabilities. Dev Med Child Neurol. 2012 ;54 (12):1079–84.

²⁰ <https://www.cdc.gov/ncbddd/actearly/whyActEarly.html>

Finding 2: The Ratio of Budgeted Community-Based and In-Home Services Waiver Slots to Members Served is Declining, Despite Increases in State and Federal Funding

Federal statute defines waivers as a predetermined number of slots that can be served at a single point in time during a fiscal year. The agency administering waivers must demonstrate in their federal application continued, annual funding capabilities for the duration of the waiver program. Waiver programs are initially approved on a three-year basis and renewed on a five-year basis.²¹ Oklahoma's DDS Waivers are budgeted five years at a time.

Table 03: This table shows the number of members budgeted for, reported number of members served, and the percent of budgeted waivers utilized for fiscal years 2018 through 2021. The numbers in this table were verified by OHCA and DDS on 10/11/21.

	FY18	FY19	FY20	FY21
Number of Members Budgeted For	5,020	5,160	5,360	5,660
Reported Members Served	4,713	4,722	4,870	4,949
Reported Utilization Rate	93.88%	91.51%	90.86%	87.44%

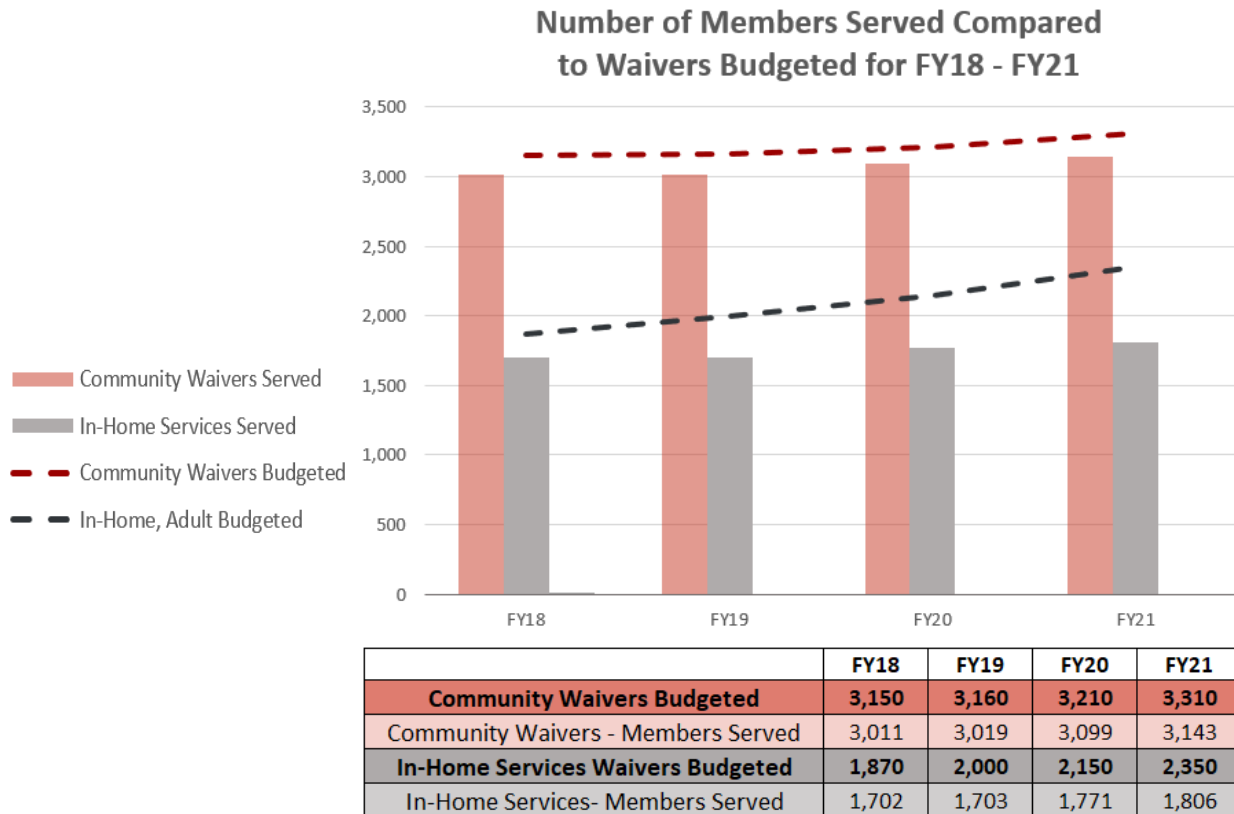
Source: Table by Legislative Office of Fiscal Transparency, data provided 10/11/21 by OHCA and confirmed by DDS

DHS' 5-year plan for the Community Waivers was approved by CMS in September 2020. The first year of the plan began in FY22. DHS will begin the process of submitting a new plan for the In-Home Service Waivers in January of 2022, with year 1 of the plan starting in FY23.

²¹ [Home & Community-Based Services 1915 \(c\)](#)

Figure 04: Community, In-Home Service Waivers over the previous four fiscal years.

This figure and the table above demonstrate the difference between the number of waivers budgeted and the number of members served across all three types of waivers being examined. As OHCA data does not distinguish between Adult and Child In-Home Service Waivers, the gray bar below represents both waivers. Table 03, above, showed the relative percent utilization of all waivers has decreased since FY18. This figure illustrates the growing gap between budgeted waivers and members served.



Source: Legislative Office of Fiscal Transparency, budgeted waivers confirmed by DHS, members served confirmed by OHCA

Per data provided by DHS, the absolute number of members served by the In-Home, Child waivers has declined while the number of budgeted waiver slots has stayed level.^{22 23} Thirty-three percent of the waiting list, or 1,890 people, are ages 3-17 and eligible for In-Home, Child waivers, which has the lowest utilization rate among the HCBS waivers.

²² October 18, 2020 email from DHS

²³ DHS 5-year plan submitted to CMS, which ends in FY22.

Developmental Disabilities Services Division

Agencies allocate resources to divisions based on the needs of individual programs and the intended objectives within any given fiscal year. Agencies communicate their needs to the Legislature during the budgeting process, including justifying requests for increased funding. Funding needs are fulfilled through federal funds, state appropriations, or a combination of both. In some cases – such as with Medicaid waiver programs - federal funds are offered to match state funding.

The Developmental Disabilities Services (DDS) division, which is responsible for administering DHS' waiver programs, is one of seventeen divisions within DHS. Since FY13, the Legislature has provided \$8.92 million in dedicated appropriations to DHS for the purpose of reducing the Waiting List for waiver services.²⁴

Chart 04: This chart shows the respective state and federal burden of cost trend for the Community-Based and In-Home Support Services waiver program from FY16 to FY21. Federal Medical Assistance Percentage (FMAP) fluctuates yearly based on a state's average income compared to the national average income. As shown in this chart, the FMAP for Oklahoma has generally increased over the previous five fiscal years, lessening the proportion of Oklahoma's investment into Medicaid services. This chart specifically shows the cost sharing for DHS' Community and In-Home Services waiver program.

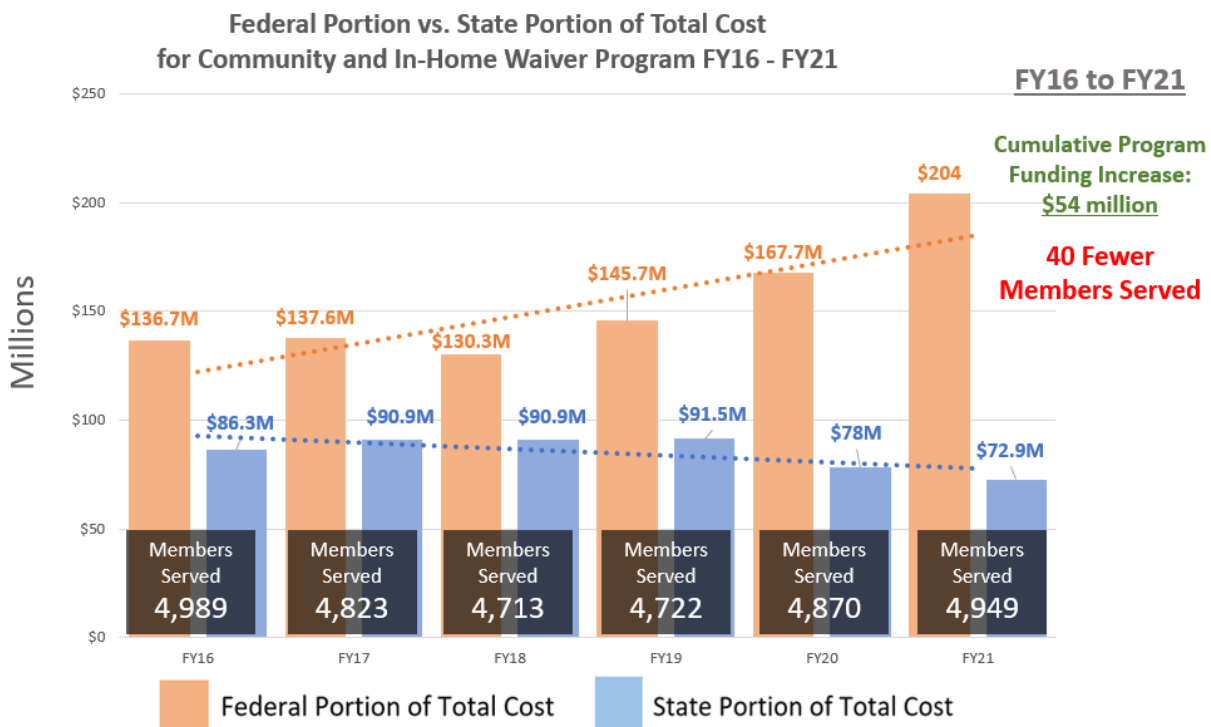


Chart by Legislative Office of Fiscal Transparency, data confirmed by OHCA 10/7/21.

²⁴ Historical Chart with trendlines located in Appendix E

From January 2016 to September 2021, total U.S. healthcare costs increased 15.27 percent.²⁵ From FY16 to FY20, national Medicaid spending on all HCBS waivers increased 25.51 percent.²⁶ ²⁷ It should be noted that the rise in total national healthcare costs cannot fully account for the increase in HCBS waiver programs nationally as more people are being served through federal mandates, which includes CMS' 2014 HCBS Final Rule.²⁸

Oklahoma observed a 10.24 percent increase in costs for the Community and In-Home Services waivers from FY16 to FY20. However, the cost of these three waivers grew to 24.24 percent by FY21.²⁹

Agency-Perceived Challenges

DHS claims its ability to operate the Community and In-Home Services Waivers has been limited by the number of providers, provider rates, technology, and statutes.³⁰ Below, LOFT evaluates the limiting factors of these perceived challenges.

Providers

According to OHCA, DDS' Waiver Program shares the same provider network as all Medicaid services offered within Oklahoma. OHCA and DDS routinely work to increase the number of in-network providers for Oklahoma's Medicaid plan. DDS can work with out-of-network providers to fulfill services, with OHCA having final approval of any provider based on their federal "compliance" designation.³¹

LOFT observed no correlation between the number of Medicaid providers and the number of members being served. The lack of correlation is attributed to the fact Waivers are predetermined over a five-year period. The five-year plans are based on the currently available resources, including the number of providers. Adding providers alone - even providers specific to Intellectual and Developmental Disabilities (I/DD) - would not increase the number of members being served unless there was a corresponding increase in program waiver slots.

²⁵ [St. Louis Federal Reserve CPI Medical Cost Index](#)

²⁶ [Medicaid.gov Financial Management Reports](#)

²⁷ 2021 CMS data not available at the time of this report.

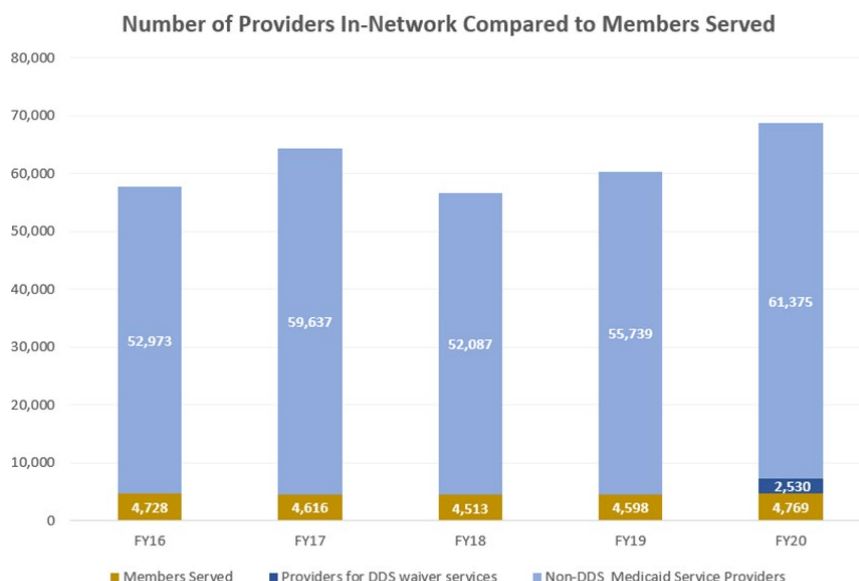
²⁸ [2014 HCBS Final Rule, CMS](#)

²⁹ OHCA data provided September 21, 2021

³⁰ October 2020 entrance conference with DHS, July 8th 2021 meeting, and August 27th 2021 teleconference.

³¹ Information for this section was provided by OHCA or from the 2020 Waiver application submitted to CMS.

Chart 05: Total number of Medicaid Providers within Oklahoma. This chart shows total Medicaid Providers over the previous five fiscal years compared to the number of Members Served within the same period. Data regarding the number of providers for DDS waiver services was not available for FY16 to FY19. The FY20 figure for the number of providers for DDS waiver services was provided by OHCA. OHCA reported over 69,000 service providers, of which 2,530³² were dedicated to providing DDS waiver services in FY20, leaving 61,375 non-DDS waiver service providers remaining.



Source: Legislative Office of Fiscal Transparency, data provided by OHCA

Provider Rates

The OHCA State Plan Amendment Rate Committee (SPARC) reviews and sets all service rates for Medicaid services. Final consideration and approval of all provider rates is given to the OHCA Board. Rates for the DDS Waiver Program are determined by one of two methodologies: “fixed and uniform,” or individual rate for services.³³

Typical services under the fixed rate are habilitation training, occupational and physical therapy, respite care, specialized medical supplies and assistive technology, pre-vocational, and supported employment. Services for individual rates are utilized in situations where a provider’s variable costs do not allow for a fixed and uniform rate.

According to DHS, a provider rate study is in progress with the intent to establish more providers for the DDS Waiver Program. OHCA, which shares a provider network with DHS, will determine the rates. Table 05, below, displays the various mechanisms available to the State to stabilize and increase provider rates.

³² OHCA data. Represents total DDS vendors in Oklahoma and includes vendors with multiple locations.

³³ Information for this section was provided by OHCA or obtained through Oklahoma’s 2020 Waiver application submitted to CMS.

Table 04: *There are three State entities that can stabilize or increase provider rates; mechanisms include a fund created by the Legislature, efficiency incentive payments administered by DHS, and COVID-related rate stabilization payments from OHCA.*

State Entity	Impact on Provider Rates
Legislature	Reimbursement Rate Stabilization Fund, originally for declines in the FMAP rate and later broadened, or additional appropriations.
DHS	Some amount of the difference between the budgeted and actual waiver amount is paid to incentivize efficiencies.
OHCA	COVID-related Reimbursements Rate Stabilization: 20% every quarter, retroactively from April 2021 to September 2021.

Source: Legislative Office of Fiscal Transparency

The Legislature created a special fund in 2019 to stabilize provider rates.³⁴ DHS also utilizes one-time funds to provide incentive payments to providers.³⁵ LOFT found no methodology showing how these payments are determined. OHCA has stated an interest in developing selection and performance-based criteria for all Medicaid vendors.³⁶

Federal pandemic relief funds have been used to keep providers solvent during and throughout the recent health crisis. Additionally, state funds have been used to increase provider rates. Between 2016 and 2020, the weighted average costs of Community and In-Home Services waivers increased nearly 13 percent. Most of the waiver costs are from paying for services through providers.³⁷

³⁴ HB 2767 (2019) established a preservation fund to maintain reimbursement rates to providers due to declines in the Federal Medical Assistance Percentages (FMAP). SB 1937 (2020) eliminated the provision allowing the fund to be utilized only in the case of declining FMAP.

³⁵ August 27th, 2021 tele-conference with DHS.

³⁶ September 20th, 2021 Exit Conference with OHCA.

³⁷ This information, as well as the information presented in Table 06, was provided by OHCA.

Table 05: Five Most-Utilized Services for the DDS Waiver Program from FY16 to FY21. The column on the far right of each table shows the change in expenditures of the corresponding service from FY16 to FY21.

FY16		FY21	
Type of Service	Community		
Direct Support	\$123,359,967	\$175,493,185	42.26%
Group Home	\$22,045,391	\$29,368,413	33.22%
Employee Training Specialist	\$22,717,413	\$18,150,879	-20.10%
Behavioral Health	\$5,618,300	\$6,320,195	12.49%
Transportation Services	\$5,497,341	\$4,025,023	-26.78%

FY16		FY21	
Type of Service	In-Home Support		
Direct Support	\$18,455,125	\$20,895,936	13.23%
Employee Training Specialist	\$3,835,246	\$2,523,505	-34.20%
Adult Day Care	\$793,885	\$554,932	-30.10%
Transportation Services	\$636,625	\$513,349	-19.36%
Medical Supplies/DMEPOS	\$656,332	\$347,738	-47.02%

Source: Legislative Office of Fiscal Transparency, data from OHCA

Technology

DDS has stated database management is a key limitation to understanding member needs. Additionally, DDS has expressed current limitations with their operating system. The partnership with Liberty should provide data to DDS to make more informed decisions. DDS is in the process of obtaining additional software to assist in managing the operations of the Waiver Program.³⁸

The current system used by DDS is a DOS-based system and is used across various State agencies. Should DDS obtain a new case management software apart from what is being provided by Liberty, OHCA would likely need to create a patch for the systems to share information or would need to switch to the same software. This process will be an additional cost and may further delay processing of waivers. Additionally, though the current system is antiquated, the capabilities are robust. DDS' current limitations are based more on sufficient expertise to understand the innerworkings of the software and up-front case management to obtain the data needed.

³⁸ As relayed to LOFT by DHS personnel on July 8th, 2021.



Medicaid and Administrative Rules Regarding In-Take

DHS has stated “Medicaid rules” prevent the agency from conducting an in-take process capturing an individual’s needs upon joining the Waiting List. DHS asserts this action would initiate a “time clock” by identifying a need. LOFT’s evaluation found no evidence of state or federal statutes with time constraints that would prohibit in-take of individuals and assumes DHS is misinterpreting the required window to provide services.

At the Federal level, the DDS Waiver Program is bound by the Social Security Act (SSA), specifically Section 1915 (c). This section of the SSA defines waivers and provides the rules of governing. At the state level, OHCA Administrative Rules govern the DDS Waiver Program. These administrative rules stipulate a “time clock”: §317-40-1-(e) states “...**when resources are sufficient for initiation** of HCBS Waiver services, DDS ensures action regarding a request for services occurs within 45-calendar days.” Based on evaluation of federal and state rules, LOFT finds no limitations as to when case management can be initiated. The requirement to provide services within 45 days is only triggered when both an individual’s need has been identified and resources are available.

In 2014, the Center for Medicare and Medicaid Services issued rule changes for 1915 (c) Home and Community-Based Services (HCBS) Waivers. Commonly referred to as “CMS Final Rule 2014,” the changes enhance states’ flexibility for waiver design with the intent of adding providers focused on community settings and ensuring person-centered planning.³⁹ States have until March 2022 to become fully compliant with the changes.⁴⁰

Person-centered planning is required by federal statute; independent assessments are further required by federal statute upon the determination of eligibility for waiver services. Both the person-centered plan and independent assessment must be updated or revised at least every 12 months, per federal statute.⁴¹ ⁴²

³⁹ [DEPARTMENT OF HEALTH & HUMAN SERVICES \(medicaid.gov\)](https://www.medicaid.gov)

⁴⁰ [The Medicaid HCBS Settings Rules: What You Should Know! \(ndrn.org\)](https://www.ndrn.org)

⁴¹ [42 CFR § 441.725 - Person-centered service plan. | CFR | US Law | LII / Legal Information Institute \(cornell.edu\)](#)

⁴² [42 CFR § 441.720 - Independent assessment. | CFR | US Law | LII / Legal Information Institute \(cornell.edu\)](#)

Finding 3: There Are Both Immediate and Long-Term Opportunities to Increase the Number of People Served by Community and Home-Based Services Waivers

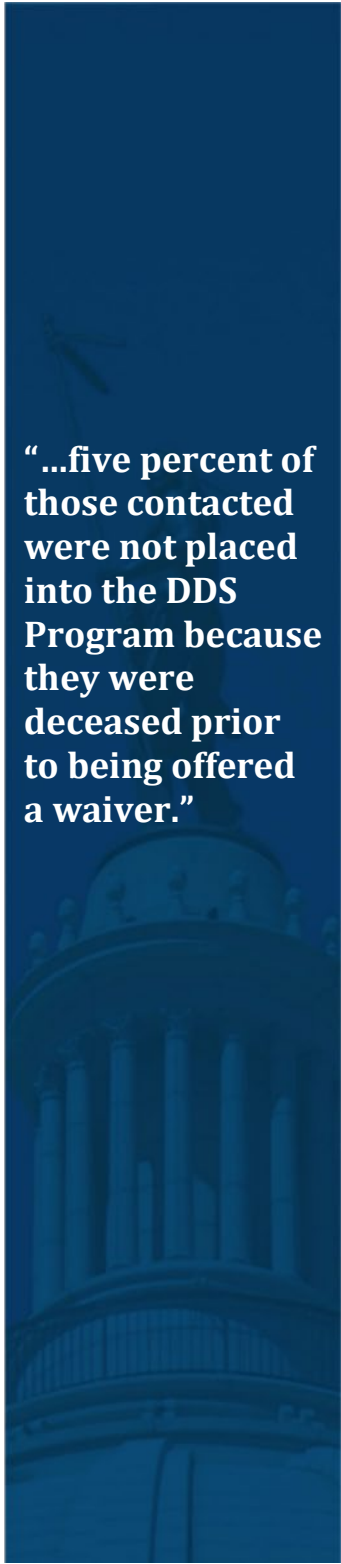
The Legislature has been clear in its intent for new funds to be used to directly serve those who have been waiting for waiver services. Senate Bill 1932, a 2020 “budget limitation” bill providing details for how the Department of Human Services should expend its annual budget, states the additional \$1.92 million in funding ***“shall be used to provide additional services and programs for persons with developmental disabilities in order to reduce the size of the Developmental Disabilities Services Division Waiting List based on need and shall be used to supplement rather than replace existing resources and programs.”***

In response to LOFT’s inquiry about how the Legislature’s dedicated funds have been used, DHS stated the funds were “applied to the agency’s bottom line.”⁴³ DDS further acknowledged “erroneous calculation and assumptions” had been used to determine how many people have been moved off the Waiting List.⁴⁴ According to DDS, in previous years, the agency identified 400 people to be contacted to determine if services were still needed. Based on new assumptions and calculations, DDS believes it could identify 800 people in 2021 to potentially move into services.

According to the data provided by DDS, 431 individuals were contacted through August of 2021. Of those contacted, approximately 52 percent were not placed into Community or In-Home Services.⁴⁵ The five most common reasons for not placing a person into waiver services were:

- No response received (20.54 percent)
- Declined services (19.2 percent)
- Non-cooperation (14.73 percent)
- Unable to locate (14.73 percent)
- Chose to remain on the Waiting List (12.5 percent).

Of note, approximately five percent of those contacted were not placed into the DDS Program because they were deceased prior to being offered a waiver.



“...five percent of those contacted were not placed into the DDS Program because they were deceased prior to being offered a waiver.”

⁴³ July 8, 2021 LOFT Meeting with DHS.

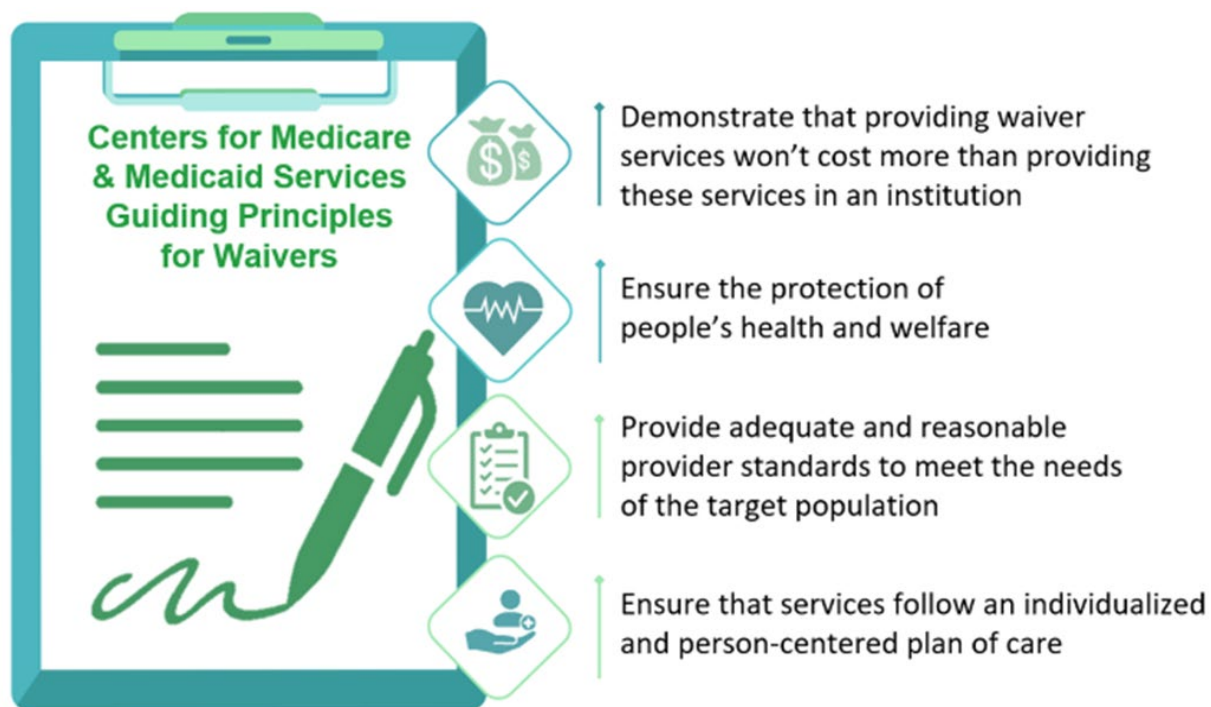
⁴⁴ August 3, 2021 email from DHS to LOFT.

⁴⁵ June 22, 2021 email from DHS to LOFT.

Current Medicaid Flexibility for States

If Oklahoma desired to change its waiver program, it has the flexibility to do so. Both DHS and Medicaid rules confirm there are broad guidelines for states to design their waivers.^{46 47} While there are numerous statutes and Medicaid rules which govern waivers, CMS identifies four guiding principles:⁴⁸

Figure 05: The Four Guiding Principles of Medicaid Waiver Programs, from Centers for Medicare & Medicaid Services (CMS).



Source: Legislative Office of Fiscal Transparency

Oklahoma's Governance Structure

DHS has 17 divisions offering 65 core services.⁴⁹ If the Development Disabilities Services (DDS),⁵⁰ the division subject to this evaluation, were a standalone agency, it would be the eighth largest agency in Oklahoma based on FY21 appropriations.⁵¹ DDS has full strategic and operational control of the Community and In-Home Services waivers. According to DDS, there are currently 453 employees within this division, with 262 dedicated to case management.

⁴⁶ Developmental Disabilities Services (DDS) Oklahoma Department of Human Services IHSW for Adults – Waiver 0343 Annual Report FY2020.

⁴⁷ [Home & Community-Based Services 1915 \(c\)](#).

⁴⁸ Ibid.

⁴⁹ [Oklahoma Human Services, Organizational Information](#).

⁵⁰ Appendix J for DHS' FTE breakout for each division.

⁵¹ [FY21 Appropriations \(oksenate.gov\)](#)

DDS provides services for persons three years and older who have a primary diagnosis of an intellectual and/or developmental disability. Through Medicaid funding, this program offers individualized community services for individuals and their families. DDS also offers a wide variety of State-funded services to “assist with financial support, respite, employment and out of home residential care.”⁵²

Federal regulations place accountability of the Waiver program with the Oklahoma Health Care Authority (OHCA), which serves as the oversight entity for all Medicaid waiver programs. OHCA’s role is to collect data, report performance metrics, and ensure compliance with federal rules, regulations, and guidelines. If a program is found to be out of compliance, the Center for Medicare and Medicaid Services (CMS) will notify OHCA. If the program does not come into compliance, approval status will be removed, and the program will be terminated.

OHCA has delegated its authority to direct operations or make programmatic changes to DHS through an interagency agreement. This document provides guidance for how the two agencies will cooperate in developing the waiver plans’ operations, rules, and how they will address problems.

Figure 06: Functions by Agency related to oversight of Community and In-Home Based Waivers. The figure reflects duplication of administrative functions between the Oklahoma Health Care Authority (OHCA) as the Medicaid Agency, and the Oklahoma Department of Human Services (DHS) as the Operating Agency for the Community. Appendix N includes copies of state waiver applications from Washington and Oregon, two states structured similar to Oklahoma, as a point of comparison.

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

Source: OHCA’s Medicaid Waiver Application Filed with CMS

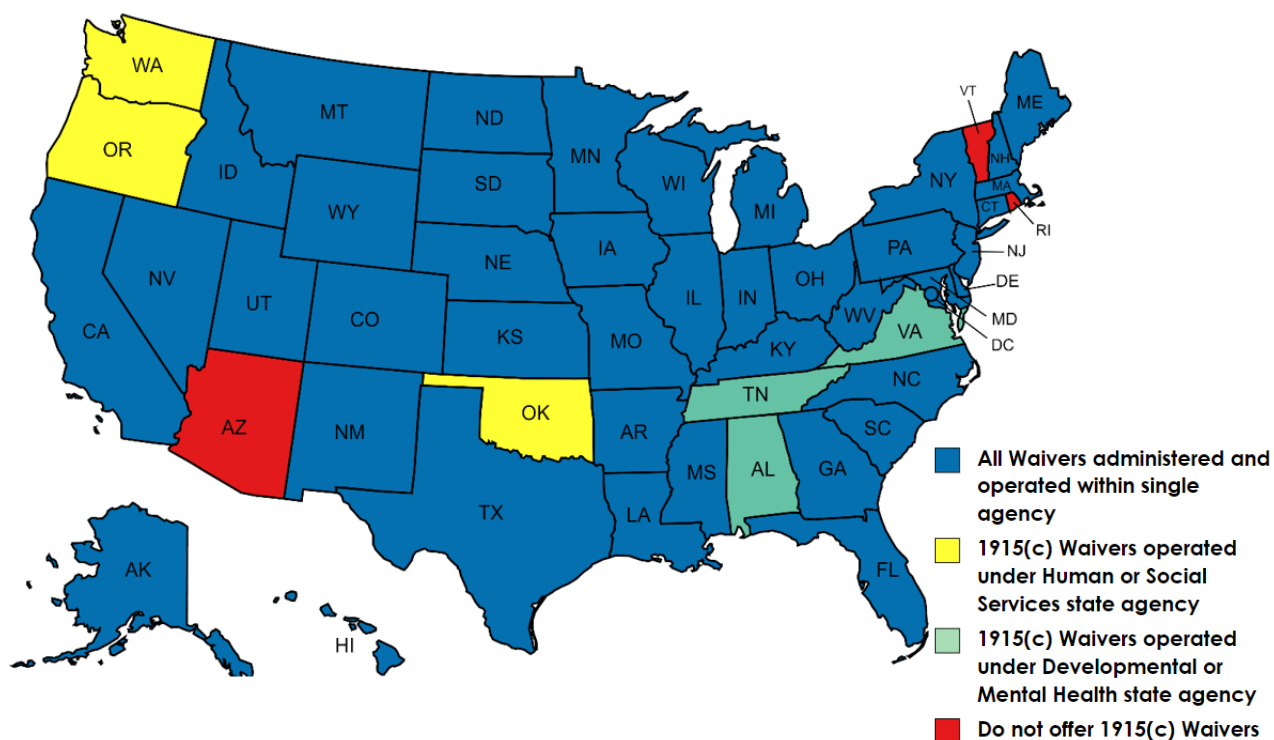
Figure 06, above, demonstrates the roles of each agency as provided in the CMS waiver application. Based on the Liberty contract, many of the functions listed under the operating agency in Figure 06 will be outsourced to Liberty, which DHS has called “case management-light.”⁵³ This outsourcing is allowable under Medicaid rules and would require an additional step in the current process.

⁵² DDS Website [Home Page \(oklahoma.gov\)](https://www.oklahoma.gov)

⁵³ LOFT’s on-site visit with DDS on July 8, 2021

Figure 07: U.S. map depicting how states have designed the Medicaid waiver program by operating entity and Medicaid agency or division. As shown, 41 of 47 states house the waiver operating entity and Medicaid within the same agency or division. Map findings derived from detailed analysis of each state's comparable 1915 (c) program application to CMS. Each application lists the designated "oversight" entity and the "operating" entity. Further research was conducted by LOFT to understand each state's structure and determine if the "oversight" entity and "operating" entity were the same agency or divisions within one agency.⁵⁴

Map of United States Showing Different Structures for 1915(c) Waivers in State Agencies



Map Source: Legislative Office of Fiscal Transparency, data from individual state's CMS applications

⁵⁴ Map created by reviewing CMS applications for each state and their respective Medicaid offices.

As shown in Figure 07, 41 of the 47 states that offer 1915 (c) waivers have the operating entity within the same agency as the Medicaid division or directly placed within the Medicaid agency. Each state must have the Medicaid agency or division listed as the “oversight” agency, but states have the freedom to choose another state agency or an outside entity as the operator for the waiver program. Most states have elected to have the Medicaid agency/division and operating agency within the same agency, which allows for vertical decision integration.

Three states do not offer 1915 (c) waivers, three designated their state’s developmental or mental health agency as their operating agency, and three – including Oklahoma - have designated the agency over human or social services as their operating agency.

State Comparisons Showing Best Practices of Programmatic Enhancements

Table 06: This table contains information on Oklahoma, Missouri, and Ohio’s Waiting Lists, including best practices identified by LOFT through direct outreach and research. DHS identified Missouri as a state its views as an industry leader, and Missouri identified Ohio as a best-practice state.

State	HCBS Waiver Total Cost	Average People Served	Weighted Cost Per Waiver	Waiting List	Understand Needs of People on Waiting List	Most Recent Fiscal Year Available	2020 FMAP Rate
Ohio	\$1,723,038,768	40,728	\$42,306	68,644	Yes	FY 20	\$2.25
	<p>•Ohio statutorily defines and provides the process of how people are placed on the Medicaid waiver waiting list through Rule 5123-9-24. While the process is encompassing, Waiting List requirements are summarized by two factors: 1) have qualifying condition, 2) and are assessed to have unmet needs for HCBS within the next 12 months.</p> <p>•Require county board of developmental disabilities to conduct needs assessment with information flowing up to Ohio Department of Medicaid. County Boards are additionally tasked with determining the level of need within their district for each type of waiver for upcoming budget year.</p> <p>•OUTCOMES: Ohio is a decentralized process which funnels information from the bottom up to formulate budgetary needs. The refined process, enacted in 2018, allows a more local understanding of needs and identification of funds. This is providing better data to not only formulate budgets, but how to structure future waivers to meet population needs.</p>						
Missouri	\$974,486,092	12,974	\$75,111	0	Yes	FY 19	\$2.55
	<p>•Missouri offers case management at the onset of the process. At times, case management is outsourced to meet the demand of current persons awaiting Medicaid waiver.</p> <p>•Frontloading case management provides metrics to allow the State to better budget Medicaid waiver needs.</p> <p>•OUTCOMES: No long-term waiting lists. By having transparent data and understanding the full needs people applying to Medicaid Waivers allows Missouri to fully fund all waiver requests each year. While there may be waiting lists which occasionally arise from the need of a particular service, this need is met within a fiscal year.</p>						
Oklahoma	\$277,035,126	4,949	\$47,135	5,711	No	FY21	\$2.60
	<p>•Little information is provided to the Legislature regarding Oklahoma's Medicaid waiver process and waiting list. A majority of information was provided through outside advocacy groups and the Oklahoma Health Care Authority. Additionally, through the course of this evaluation, LOFT discovered numerous reports and studies, dating as far back as 2011, which indicated Oklahoma could benefit from several of the best practices identified within this table. Furthermore, LOFT observed no evidence of actions taken by OHS to implement the earlier recommendations.</p> <p>OUTCOMES: Oklahoma's Community and In-home Serve Medicaid waiver process have remained mostly unchanged for over a decade.</p>						

Source: Legislative Office of Fiscal Transparency, compilation of interviews and data collection from states, KFF.org FMAP, and OHCA

DHS recommended that LOFT look at Missouri as a peer state to evaluate, largely due to Missouri’s program having no waiting list for services. Missouri then identified Ohio as another best practice state based on its operations. LOFT found both Missouri and Ohio to be highly adaptive and responsive to the population they serve.

Missouri's strategy is to fund all waiver needs, which prevents a Waiting List from forming. Ohio outsourced needs assessments to counties for quicker and more accurate information about where needs exist, and then the state develops a plan to meet those needs.

Utah and Colorado were independently researched and identified by LOFT as best practice states. These were selected based on recent programmatic changes that have shown improvements through enhanced communication with those on the Waiting List or significant advancement in program outcomes. In all four cases, each state demonstrates an understanding of the needs of their waiting list and uses front-end case management data to make program enhancements.

Table 07: This table contains information on Oklahoma, Utah, and Colorado's Waiting Lists, including best practices identified by LOFT through direct outreach and research. These states were selected by LOFT through reading prior assessments and research of current trends within their waiver programs.

State	Comparable Waivers to Community and In-Home Services Waiver Total Cost	Average People Served	Weighted Cost Per Waiver	Waiting List	Does the State Understand Needs of Members on Waiting List	Most Recent Fiscal Year Available	2020 FMAP Rate
Colorado	\$566,773,681	24,953	\$22,714	4,521	Yes	FY19	\$1.28
<ul style="list-style-type: none"> •Colorado revamped their waiver process in FY 2014. This process required moving waiver service from Human Services to Department of Health Care Policy & Financing, the state's equivalent of OHCA. This move facilitated stronger mission alignment with the Medicaid agency, provided enhanced transparency, which included outcome metrics and data to better understand the needs of people on the waiting list. •Provide annual updates on the progress and implementation of strategic initiative. •Provides public monthly updates on people served on each waiver and total cost expenditures. •Intake prior to waiting list. Places people in three categories: emergency, as soon as available, and services needed at a future date. •OUTCOMES: Increased waivers served by 48% while decreasing waiting list by 58% from FY14 to FY20. Better data allowed for the reduction of costs and development of waivers to better serve population needs. 							
Utah	\$379,495,200	6,167	\$61,536	4358	Yes	FY20	\$2.90
<ul style="list-style-type: none"> •Utah recently changed the state's intake process. Utah's Needs Assessment Questionnaire (NAQ) is a weighted formula which considers the severity of a person's needs, the amount of time person has been on the waiting list, and other factors to determine a person's actual wait list spot. •Transparency dashboard with annual figures, performance metrics, and costs provided to the public. •OUTCOMES: Though changes were only enacted within the past three fiscal years, positive outcomes have been observed. First is a better understanding of the needs of the people on the waiting list. Second is the increased engagement from case managers allows the people of the waiting list to know where they, as individuals, stand within the system. Having a better understanding of when services would be available provides clarity to the families and allows for enhance family planning needs. 							
Oklahoma	\$277,035,126	4,949	\$47,135	5,711	No	FY21	\$2.60
<ul style="list-style-type: none"> •Little information is provided to the Legislature regarding Oklahoma's Medicaid waiver process and waiting list. A majority of information was provided through outside advocacy groups and the Oklahoma Health Care Authority. Additionally, through the course of this evaluation, LOFT discovered numerous reports and studies, dating as far back as 2011, which indicated Oklahoma could benefit from several of the best practices identified within this table. Furthermore, LOFT observed no evidence of actions taken by OHS to implement the earlier recommendations. OUTCOMES: Oklahoma's Community and In-home Serve Medicaid waiver process have remained mostly unchanged for over a decade. 							

Source: Legislative Office of Fiscal Transparency, compilation of interviews and data collection from states, KFF.org FMAP, and OHCA



Flexibility in Waiver Design

The In-Home Services Waivers for children and adults resulted from a 1997 study of the Waiting List. That study, conducted by Oklahoma State University, surveyed all persons waiting at that time to identify the services most needed. This revealed that the majority of people waiting lived in their own home or the home of a family member and needed help with daily living activities, respite care and vocational services.⁵⁵ The changes resulting from this study were the last time waivers were adjusted in the DDS Waiver Program.

States are granted flexibility in designing waivers to meet their state's specific needs, such as the In-Home Waivers Oklahoma established after the 1997 study. Oklahoma offers four types of HCBS 1915 (c) waivers. States have the flexibility to offer and provide any, all, or none of the HCBS waivers. This is observed in Figure 07 on page 21 where only three states do not offer the 1915 (c) waiver.

Of the states that provide a 1915 (c) waiver, several offer up to six programs within this category while others offer as few as one. The number of 1915 (c) waiver programs a state offers should be predicated on a state's strategy for best serving the needs of individuals in their state. Below, LOFT details case studies of the models used in Wisconsin and Colorado to illustrate two varying strategies in delivery of waiver programs.

Case Study: Wisconsin Model

Wisconsin began addressing the state's waiver program in 1995 by conducting a cost analysis across waivers.⁵⁶ This analysis determined discrepancies between service costs across waivers which could not be attributed to the level of service needed to enter a specific waiver. Wisconsin realigned the cost structure to provide more transparency into service costs and provide consistency across waivers, and then reinvested internal savings from the efficiencies back into the program to serve more people.

Over time, Wisconsin transitioned their state's program strategy from administering multiple waivers to providing one waiver for all individuals. Wisconsin determined that one waiver offered the state the most flexibility to move people into waiver services more quickly and accurately while additionally controlling program costs. This strategy allowed the state to expand on the services covered under their state's Medicaid Plan due to having more accurate data about the costs of services. As illustrated with Oklahoma's In-Home Services, Child waiver,

⁵⁵ [Developmental Disabilities Services: History \(oklahoma.gov\)](https://www.oklahoma.gov/developmental-disabilities-services/history)

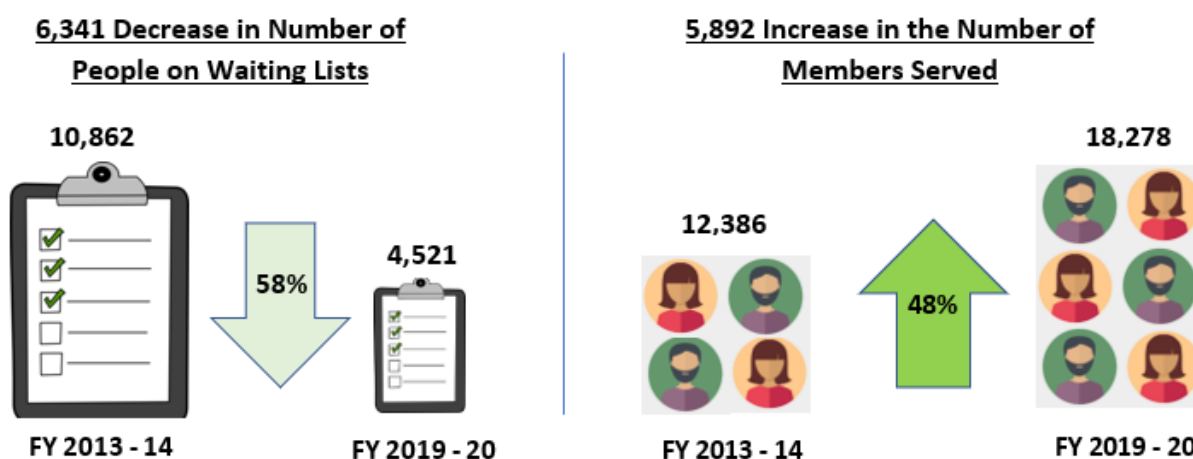
⁵⁶ LOFT conversations with the Wisconsin Department of Health and Family Services

costs for this waiver are lower because most services needed are offered through a state's Medicaid Plan or have other federal programs available to families, such as Early Childhood, which can meet family needs. Wisconsin leveraged these types of programs to maximize investments and then used the waiver program to address unmet needs.

One consistent theme of Wisconsin's program strategy was to **invest savings back into the program**. The Wisconsin Department of Health and Family Services was able to identify methods to provide services at costs lower than original appropriations. The cost savings were pumped back into the program to expand the provider network, expand waiver capacity, or offer new services that reduced waiver program needs.

Case Study: Colorado Model

Figure 08: Colorado's Waiver Program Outcomes from FY13 to FY20 (November). In FY14, Colorado's Human Services Division for HCBS Waivers was consolidated into the Department of Health Care Policy & Financing, Colorado's equivalent to the Oklahoma Health Care Authority. Colorado's decision to consolidate this division under Health Care Policy & Financing was driven by a desire to produce better data for strategic decisions for program outcomes and maximize state investment to eliminate the Waiting List. This figure shows a 48 percent increase in people served with a corresponding 58 percent decline of people on the Waiting List.⁵⁷



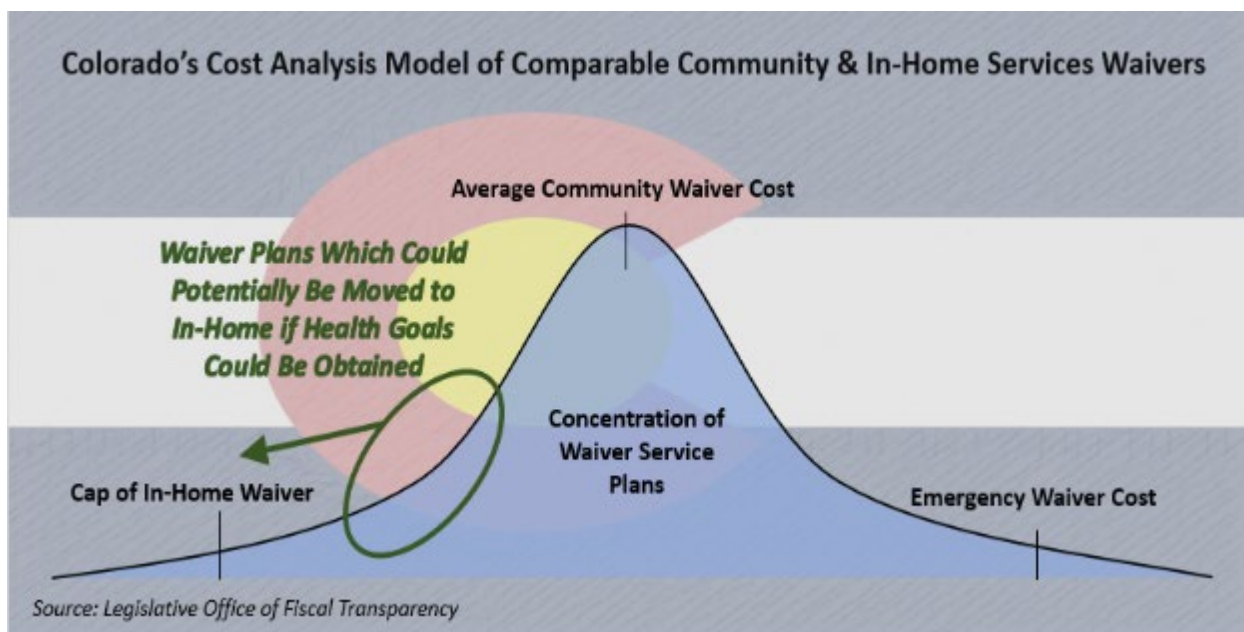
Source: The Legislative Office of Fiscal Transparency, based on a Colorado Department of Health Care Policy & Financing Annual Legislative Report.

From FY13 to November of FY20, **Colorado's Department of Health Care Policy & Financing (HCPF) was able to decrease their Waiting List by 58 percent while increasing the number of members served on waivers by 48 percent.** The change in both waiver growth and waiting list decline is attributed to the Colorado Legislature's strategic decision to have their state's I/DD waiver program be absorbed by HCPF. This move increased the level of data analysis available to the waiver program with the least amount of strategic interference (vertical decision making).

⁵⁷ [Colorado Department of Health Care Policy & Financing's Annual Update to State Legislatures](#)

Colorado's analysis concluded there were a cluster of waiver plans whose eligibility requirements were slightly above the threshold to qualify for the In-Home Services waiver but did not rise to the level of needing institutional care. Colorado created two new waivers that were designed to specifically enable individuals to transition into lower tiered In-Home Services. This approach reduced program costs by reducing the number of higher-cost waivers needed and achieving outcomes which allowed participants to transition into more cost-effective waivers.

Figure 09: Cost Structure Analysis of Colorado's Waiver. This infographic shows a normal distribution (bell curve) of Colorado's actual waiver service plan costs as compared to the budget amounts. The "green circle" shows a grouping of plans in Colorado's program which were slightly above the cap for In-Home Services but below the level of needing institutionalized care. Colorado created two new waivers to serve the group identified in their analysis. Goal of the new waivers was to assist people in obtaining health outcome goals which qualified them to move from the high-cost institutionalized care waivers to the more cost-effective In-Home Services waivers. By expanding their types of waivers offered under their program from four to six, Colorado reduced the weighted average cost to serve waivers. Colorado reinvested the savings into their program which further limited the additional investment needed from the State to serve more people on the Waiting List.



As shown in Table 09 on page 27, Colorado reduced the weighted average cost per waiver by 42 percent after implementing the recommendations from their cost analysis (shown in Figure 09). Reinvesting those savings back into their waiver program allowed the Colorado Legislature to **increase the number of people served by 115 percent with only a 23 percent increase in investment.**

Table 08: Colorado Waiver Program Since FY14. This table shows a 115 percent increase in the average number of members served in a fiscal year compared to a 23 percent increase in investment. This was achieved in large part through legislation and waiver restructuring, which decreased waiver costs by 42 percent over six fiscal years.

Colorado Waiver Program							
	FY14	FY15	FY16	FY17	FY18	FY19	Percent Change
Average Members Served	11,629	10,704	11,420	11,420	24,953	24,953	115%
Total Program Cost	\$444,356,987	\$449,568,320	\$471,777,277	\$471,777,277	\$548,426,444	\$548,426,444	23%
Average Cost Per Waiver	\$38,211	\$42,000	\$41,311	\$41,311	\$21,978	\$21,978	-42%
FMAP	\$1.00	\$1.04	\$1.03	\$1.00	\$1.00	\$1.00	

Source: Legislative Office of Fiscal Transparency, data provided by Colorado Department of Health Care Policy & Financing

Potential Changes to Better Serve Those Who are Waiting

One of the key objectives of this evaluation is to determine what resources would be required to serve all those currently on the Waiting List. LOFT took three approaches to this work: first, LOFT estimated the annual investment required, assuming no changes in waiting population or changes in how the program is delivered. Under this scenario, the State would need to dedicate an additional \$16 million in annual funding. Second, LOFT forecasted the impact of amending DHS' FY23 allocation of waiver slots and reinvesting resulting savings into the high-demand In-Home, Child Waiver. Last, LOFT estimated the impact of investing an additional \$5 million in State funds into just the In-Home Services, Child waiver serving children ages 3-17.

Scenario 1: LOFT's Estimation of Annual Resources Necessary to Serve All Those Currently Waiting for Services, With No Programmatic Changes⁵⁸

Table 09: LOFT's estimation of the annual cost to serve ALL Waiver eligible people on DHS' current Waiting List. This figure is based on current program trends and costs. This calculation is as of September 22, 2021, using March 30, 2021 Waiting List figures. Additionally, this figure presumes no programmatic changes.

Estimated Annual Investment to Serve All Eligible People on Waiting List	
\$49,811,724.00	
Oklahoma's Portion	Federal Portion
\$16,138,998.58	\$33,672,725.42

Source: Legislative Office of Fiscal Transparency, using data provided and confirmed by DHS

The above table shows LOFT's estimate of the investment needed for the State to provide a waiver slot to all those currently on the Waiting List. **This estimate is based on the current program parameters and assumes that 55 percent of those contacted would transition into Community and In-Home Waivers.**⁵⁹ However, information from the Liberty assessment could

⁵⁸ See Appendix A for full methodology. Calculations used FY23 Blended FMAP estimate

⁵⁹ DHS stated in October 2020 Entrance Conference historically 50-55 percent of people contacted move into waiver services. Data provided by DHS through email on June 22, 2021.

enhance programmatic changes and lower the amount required. A more precise estimation could be obtained once data from the Liberty Assessments becomes publicly available.

Estimates in Table 09 were benchmarked against Utah, which was included in previous waiver program assessments as a peer state to Oklahoma based on similar challenges with its waiting list. Utah recently revamped their Waiver Waiting List from “first on, first off” to a composite score that factors an individual’s needs and length of time waiting. As of FY21, Utah has twice the number of Waiver eligible people on their Waiting List and estimates the total investment to serve all people would be approximately \$300 million, annually.

Table 10: DDS Community Waiver Program Forecast as Presented to CMS. This table reflects DDS’ estimate for the next five fiscal years, as submitted to CMS for renewal of respective waiver programs. The table shows the number of Community and In-Home Waivers for both adult and children for FY21 and FY22, with the Community Waiver’s forecasted plan for the next five years. In-Home, Child Waiver remained flat at 250 Waivers during the current five-year plan. These waivers comprise 4.53 percent of total waivers offered by DDS in FY22. This is contrasted to 33.64 percent of the total, unadjusted Waiting List being comprised of those between the ages of 3-17 (as of March 31, 2021).

Waiver Program Forecasts	FY21	FY22	FY23	FY24	FY25	FY26
Community						
Number of Waivers	3,310	3,310	3,376	3,443	3,511	3,596
Forecasted Cost per Waiver	\$69,996	\$67,451	\$68,850	\$70,580	\$72,382	\$74,272
Total Cost	\$231,686,760	\$223,262,810	\$232,437,600	\$243,006,940	\$254,133,202	\$267,082,112
In-Home, Adult						
Number of Waivers	2,100	2,200	DHS process to forecast next five-year plan begins January 2022 with expected approval by CMS in July 2022			
Forecasted Cost per Waiver	\$14,446	\$14,128				
Total Cost	\$30,336,600	\$31,081,600				
In-Home, Child						
Number of Waivers	250	250	DHS process to forecast next five-year plan begins January 2022 with expected approval by CMS in July 2022			
Budgeted Cost per Waiver	\$4,967	\$4,967				
Total Cost	\$1,241,750	\$1,241,750				
Total Program Cost	\$263,265,110	\$255,586,160	TBD	TBD	TBD	TBD

Source: Legislative Office of Fiscal Transparency, data and detail provided by DHS

*Note: FY22 to FY26 for Community Waiver begins new five-year plan

As previously noted within this report, Medicaid requires the submittal of any waiver program renewal to be accompanied with a five-year forecast of the predetermined number of waivers, and the cost to serve those waivers. Of note is the fact In-Home, Child Waiver has remained flat even though the age bracket of 3-17 comprises approximately 33.6 percent of the entire Waiting List (1,890 total children waiting as of this report).

Using data provided by DHS regarding the Waiting List and the above projections, LOFT estimates that with one change to the forecasted allocation of waivers, 31.3 percent of all children could receive waivers by FY23.

Scenario 2: Amending FY23 Waiver Allocations and Reinvesting Savings into the High-Demand In-Home, Child Waiver

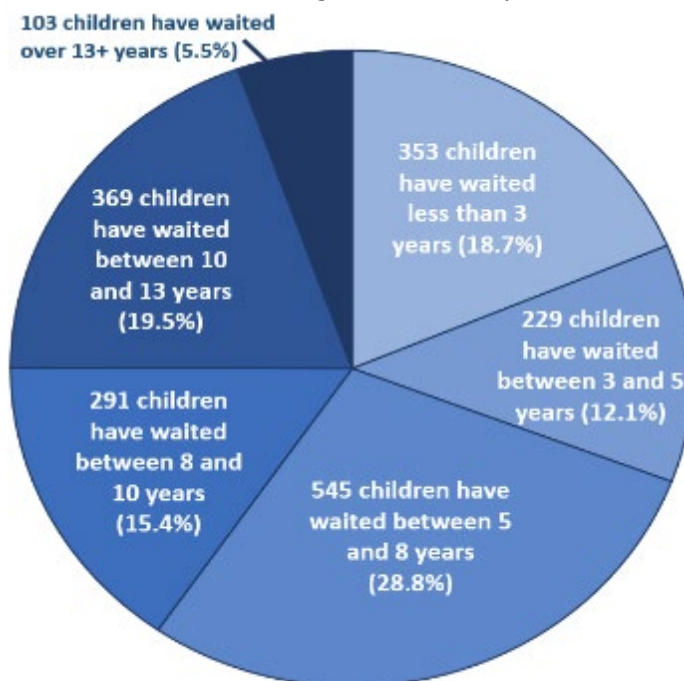
Figure 03 on page 8 showed that 1,890 children are currently on the Waiting List. Figure 10, right, shows how long these children have been waiting: 34.9% of children on the waiting list have waited for between 8 and 13 years for services.⁶⁰

Despite not fully utilizing Community Waiver capacity, DDS has forecasted an increase in waiver capacity every year from FY21 to FY25. **LOFT estimates 693 additional children could be served by FY23** by limiting the Community Waiver capacity increase to 3,326 (16 new slots), as opposed to increasing it to 3,376 in FY23 as planned. The projected funds, which have already been submitted to CMS, could be reinvested into the In-Home, Child waiver to create the additional capacity. As referenced in Finding 1, In-Home Services are one of the greatest needs for those on the Waiting List. As noted in Finding 2, DHS is not utilizing the Community Waiver at full capacity, even when accounting for the 100 reserved emergency waivers.⁶¹ Emergency Waivers are reserved to serve those whose “health or safety is directly endangered, or who may endanger others, and for which there is no other resolution.”⁶²

Figure 10, above, shows the current number of children grouped by length of time on the Waiting List. Excluding the 103 children who have waited longer than 13 years, as this group will likely transition into In-Home, Adult or Community Waivers by FY23, all other groups listed in Figure 10 could be served by limiting the Community Waiver to 3,310 and reinvesting into the In-Home, Child Waiver.

LOFT evaluated the impact of re-forecasting the number of community waivers and reinvesting the savings into In-Home Child waivers. The analysis finds that reducing the number of community waivers by 50 allows for 693 more children to be served due to cost differentials between the two waivers.⁶³ Moreover, it would reduce the average wait time for waiver services by two years. This is displayed in Figure 11 on the next page.

Figure 10: Number of children aged 3-17 on the Waiting List by length of time waiting. This chart shows that 103 children have been waiting more than 13 years.



⁶⁰ This demographic information was provided by DHS

⁶¹ DDS Waiver Renewal Application to CMS

⁶² [OHCA Policies and Rules governing HCBS Waivers 317:40-1-1](#)

⁶³ Cost differential data was sourced from the CMS application

Figure 11: Strategic Allocation of Future Community Waiver Increases. This infographic depicts how reallocating resources from a projected increase of the Community Waiver, which is currently underutilized, could impact 693 children waiting to receive In-Home Services. This presumes all people on the Waiting List are eligible and require immediate services. Noted throughout the report, prior assessments show in-home services represent the largest portion of requested services.

By reallocating the planned expansion of **50 Waiver slots** in the underutilized **Community Waiver** to **In-Home, Child Waiver slots**, Oklahoma could serve **693 more children**



Source: Legislative Office of Fiscal Transparency, calculated using DHS' projected program costs

This strategy focused on the In-Home, Child Waiver Services, but, if the State chose to instead target serving more In-Home Services for Adults waivers, an additional 346 waiver slots could be created.

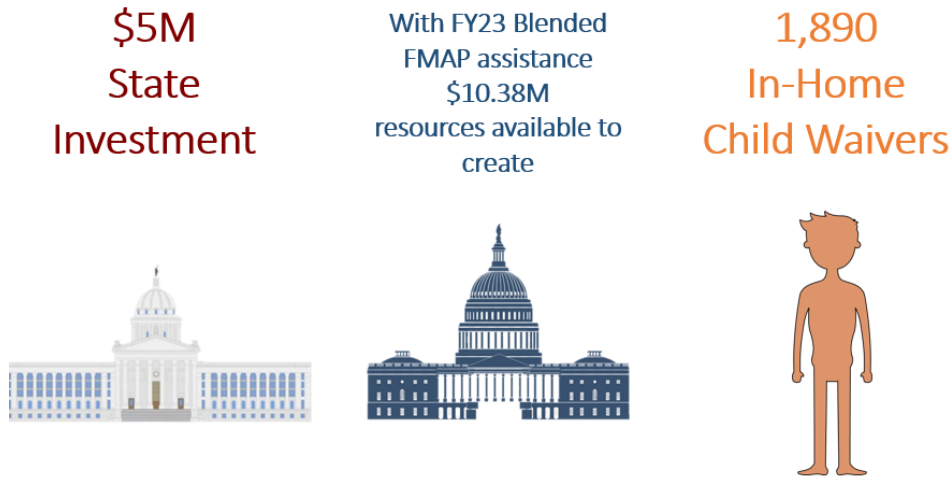
DHS appears to have enacted a similar strategy for FY21 when the agency reduced budgeted Community Waiver slots by 90 and increased In-Home, Adult Service Waivers by 200.

Scenario 3: Strategic Investment of \$5 Million Into In-Home, Child Waivers

DHS has stated the Waiting List “could be fixed with \$5 million.”⁶⁴ While LOFT’s analysis for Scenario 1 shows the required total investment would exceed \$49 million, LOFT analyzed the impact a \$5 million increase in State funds would have on the 3-17 age group, which represents one-third of those waiting for services. In Scenario 3, which would require a programmatic targeted shift away from “first on, first off” processing of all waivers, demonstrates that a strategic investment of \$5 million into the In-Home, Child Waivers would serve all 1,890 children on the Waiting List with additional capacity for 424 In-Home, Adult Waivers. This scenario presents just one example of how additional investments can be paired with program changes to target specific demographics, conditions, or level of need.

⁶⁴ LOFT’s entrance conference with DHS, October 2020

Figure 12: By providing \$5 million in new State funding, DHS would have the resources to serve all 1,890 children waiting for In-Home, Child Waivers.



Source: Legislative Office of Fiscal Transparency, data from DHS 5-year plan for In-Home Services submitted to CMS

This strategy focused on the In-Home, Child Waiver Services with excess funds diverted to In-Home, Adult Waiver Services, but, if the State chose to instead target serving more In-Home Services for Adults waivers, an additional 1,088 waiver slots could be created.

Policy Considerations and Agency Recommendations

Policy Considerations

The Legislature may consider the following:

- For improved transparency, repurpose an existing fund or create a program stabilization fund. Identified unutilized funds or realized programs savings could be deposited for targeted reinvestments.
- Requiring a more transparent process to establish provider incentive payments, with an emphasis on paying incentives based on performance or metrics the state wishes to achieve, such as adding specific vendors to allow for higher utilization of waivers.
- Requiring annual updates be provided to the Legislature regarding a strategic plan to increase the number of people served from the Community and In-Home Services Waiver Program Waiting List. Updates should reflect progress made toward milestone objectives.
- Requiring publicly available monthly data updates reflecting current cost expenditures and number of waivers being utilized by month and year to date.
- Dedicating funds for a third-party operational audit to identify inefficiencies and duplication of services within the Developmental Disabilities Services division and its partners, which could create internal savings to be reinvested into the program.
- Requiring that data collected by Liberty Healthcare of Oklahoma (Liberty) and reported to the Department of Human Services be made publicly available online and updated regularly to provide, at minimum, the number of people on the Waiting List.

Agency Recommendations

DHS should:

- Create a strategic plan with goals and milestone objectives for how the Developmental Disabilities Services Waiver Program will be enhanced. Goals should be fully achievable two years before the State's renewal deadline for the current program.
- Conduct a cost analysis of its waiver structure to identify opportunities for adding or adjusting waiver services to improve cost effectiveness and to enable more people to be moved onto waivers.
- Revise management of the Waiting List so that only those who need immediate services are shown on the public-facing Waiting List. The agency should maintain a separate list of those who anticipate needs in the future.
- Make the data reporting required in the Liberty contract publicly available, including data on the cost of the waiver program and the number of waivers being utilized.
- Enhance communications with the people on the Waiting List, including communication of any program changes and potential impact, as well as estimates for wait times.
- Deposit any one-time funds, such as service costs of an individual plan being less than budgeted, or other cost savings generated through the program into the program stabilization fund. Funds should be reinvested into the programs to achieve goals listed within a strategic plan.

About the Legislative Office of Fiscal Transparency

Mission

To assist the Oklahoma Legislature in making informed, data-driven decisions that will serve the citizens of Oklahoma by ensuring accountability in state government, efficient use of resources, and effective programs and services.

Vision

LOFT will provide timely, objective, factual, non-partisan, and easily understood information to facilitate informed decision-making and to ensure government spending is efficient and transparent, adds value, and delivers intended outcomes. LOFT will analyze performance outcomes, identify programmatic and operational improvements, identify duplications of services across state entities, and examine the efficacy of expenditures to an entity's mission. LOFT strives to become a foundational resource to assist the State Legislature's work, serving as a partner to both state governmental entities and lawmakers, with a shared goal of improving state government.

Authority

With the passage of SB1 during the 2019 legislative session, LOFT has statutory authority to examine and evaluate the finances and operations of all departments, agencies, and institutions of Oklahoma and all its political subdivisions.

Created to assist the Legislature in performing its duties, LOFT's operations are overseen by a legislative committee. The 14-member Legislative Oversight Committee (LOC) is appointed by the Speaker of the House and Senate Pro Tempore and receives LOFT's reports of findings.

The LOC may identify specific agency programs, activities, or functions for LOFT to evaluate. LOFT may further submit recommendations for statutory changes identified as having the ability to improve government effectiveness and efficiency.



Definitions

Federal Medical Assistance Percentage (FMAP):⁶⁵ The FMAP has many different uses when it comes to federal medical programs. For the purposes of this report, the definition of FMAP has been limited to how it impacts the Home and Community Based Waiver Services.

FMAP is a federal cost sharing metric used to determine the federal match/reimbursement to states for programs such as Medicaid. Federal statute indicates the minimal investment by the federal government to a state is 50 percent (\$1) and a maximum investment of 83 percent (\$4.95).

The FMAP formula has remained relatively unchanged since its inception in 1965 with Medicaid was authorized the Social Security Act. FMAP uses a three-year average of the most recent state per capita income as provided by the U.S. Department of Commerce's Bureau of Economic Analysis (BEA). The 2021 FMAP was calculated using the 2016, 2017, and 2018 per capita incomes for each state. The FMAP formula is as follows:

$$\text{FMAP}_{\text{state}} = 1 - ((\text{per capita income}_{\text{state}})^2 \div (\text{per capita income}_{\text{U.S.}})^2 \times 0.45)$$

Acronyms:

- CMS - Center for Medicare and Medicaid Services
- DDS - Developmental Disabilities Services
- DHS - Oklahoma Department of Human Services
- FMAP - Federal Medical Assistance Percentage
- HCBS - Home and Community-Based Services
- HCPF - Colorado's Department of Health Care Policy & Financing
- I/DD - Intellectual and Developmental Disabilities
- Liberty - Liberty Healthcare of Oklahoma
- LOFT - Legislative Office of Fiscal Transparency
- OHCA - Oklahoma Health Care Authority
- SPARC - OHCA State Plan Amendment Rate Committee
- SSA - The Social Security Act

⁶⁵ [Congressional Research Service, FMAP - July 29, 2020](#)

Appendices

Appendix A. Methodology

Interviews were conducted with:

- Oklahoma Department of Human Services
- Oklahoma Health Care Authority
- Colorado Department of Health Care Policy and Financing
- Missouri Department of Mental Health
- Ohio Department of Medicaid
- Utah Division of Services for People with Disabilities
- Wisconsin Department of Health Services, Division of Medicaid Services
- Community Advocate Groups and members
- National Conference of State Legislators (NCSL)

The source of members served information came from both DHS and OHCA; as indicated in the report, the information provided by these two sources sometimes does not agree. Where possible, LOFT staff has independently verified the sources of information on cost of waivers served (OHCA) or waiting list information (DHS). In addition, LOFT staff have consistently used members served information that is more conservative to smooth differences in data presentation resulting from that inconsistency.

It is the purpose of LOFT to provide objective information: this report has been reviewed by LOFT staff outside of the project team to ensure accuracy, neutrality, and relevance.

Scenario 1 Methodology: LOFT utilized program data from DHS and blended FMAP data from OHCA to conduct this scenario. Assumptions are that no programmatic changes would be applied to the current operations, simply increasing investment into the DDS Waiver Program. This scenario is calculated with the presumption that 55 percent of members on the Waiting List contacted by DDS would go into the Waiver service specific to the Waiting List. Using data provided by DHS, LOFT further presumed 97 percent of people coming off the Waiting List would be moved into In-Home Services waivers. The number of members on the Waiting List was then multiplied by 55 percent (assumed qualified members), this figure was then weighted by 97 percent and 3 percent, and then multiplied by average-weighted cost of the waivers for FY21 for In-Home Services (97 percent) and Community Waiver (3 percent). FY21 average costs were provided by DHS. Oklahoma's portion was then calculated using the blended FMAP for FY23 as provided by OHCA. Lastly, it should be noted 17 members were subtracted from the March 2021 Waiting List totals because they were in the 0-3 age group, which are not covered by DDS Program Waivers. Additionally, 103 members from the 3-17 age group were recategorized into In-Home, Adult Waivers as these members would age out of the In-Home, Child Waiver prior to changes realistically being obtainable.

Scenario 2 Methodology: LOFT presumed level funding within the DDS Waiver Program with a more targeted approach to which members would be served. LOFT presumed a targeted approach of the age demographics of the 0-17 age bracket. This presumption was based on the cost-effectiveness of the In-Home, Child waiver, combined with child members comprising approximately one-third of the current Waiting List. LOFT presumed an amendment would be filed with CMS to reallocate a planned expansion Community Waivers, which is currently underutilized. LOFT used DDS' projections for the Community Waiver in FY23 to determine dollar figure which could be reallocated to the In-Home, Child Waiver. The reallocation figure was then divided by DDS' forecasted costs to determine how many In-Home, Child Waivers could be requested in the amendment to CMS. LOFT's understanding is the cost projections utilized in the CMS application are inclusive of the federal match, therefore no adjustment was needed in LOFT's calculations.

Scenario 3 Methodology: LOFT presumed a \$5 million increased investment to the DDS Waiver Program combined with a strategic approach to utilize the most cost-effective way to serve members through the In-Home, Child Waiver. The \$5 million increased investment is presumed to be State dollars, which would be maximized through the FMAP. The federal investment was calculated using the FY23 blended FMAP as provided by OHCA. The state and federal dollars were combined to determine the level of financial resources available to allocate towards serving the In-Home, Child Waivers. The final determination on the availability of In-Home, Child Waivers was calculated using DDS' projected FY22 costs for the In-Home, Child Waiver submitted in their CMS application.

Appendix B. Blue Ribbon Panel Recommendations

List of Recommendations to Governor Mary Fallin from the 2015 Blue Ribbon Panel for Developmental Disabilities

Table 11: This table shows the various strategies and recommendations made by the 2015 Governor's Blue Ribbon Panel.

2015 Governor's Blue Ribbon Panel Recommendations		
Strategy 1	Strengthen information access	<ul style="list-style-type: none"> Increasing knowledge about disability services and community resources for professionals Increasing access to information about disability services and community resources for Oklahomans with disabilities and their families <ul style="list-style-type: none"> Equipping professionals at intake points Training for families and advocates Improving information via websites, disability information web portal Sending useful, comprehensive information to those waiting
Strategy 2	Provide resource navigation and improve inter-agency service coordination	<ul style="list-style-type: none"> Strengthening service coordination at critical life points Establishing a process for all agencies to utilize regular evaluation and assessment of policies Simplifying access to services and program that involve more than one agency Developing strategies to provide resource navigation services to Oklahomans with disabilities to meet needs and provide emotional supports
Strategy 3	Provide family-to-family support to individuals and families who are currently on the Waiting List or who apply for Waiver services	<ul style="list-style-type: none"> Establishing a way for state agencies to actively connect parents and caregivers Oversight by OMES for agency budgetary planning to ensure existing funding is maintained Support new and additional funding for these networks Create an automatic referral process to the statewide family-to-family networks
Strategy 4	Assess the needs of families currently on the Waiting List	<ul style="list-style-type: none"> Implement a needs-based selection criteria for persons on the Waiting List Describe level of need in any annual appropriation request for funding to reduce the list Amend the criteria for expedited waiver services to take into account the age of the applicant, age of

		caregiver, certain medical conditions and loss of employment
Strategy 5	Build capacity of services and supports outside of those provided through DDS Waivers	<ul style="list-style-type: none"> • Simplify application through the creation of a single, centralized web-based application process • Funding a full-time position to assist caregivers in navigating application processes • Opening the DDS respite program to recipients of the Family Support Assistance Program with two or more children with disabilities in the home • Create a seamless process for children applying for personal care services that does not restrict the medical necessary determination • Modify administrative rules to assure compliance with CMS regulations regarding EPSDT • Create staff training to assure understanding of personal care services for children with IDD • Create a statewide process to increase awareness for families and staff of both OHCA and DHS on the availability of personal care services for children and adults with IDD • Better equipping school personnel to utilize transition services and plan for meaningful lives for students • Better equipping providers of employment services on how to best support young adults with IDD • Providing ongoing training for <ul style="list-style-type: none"> ○ community providers, schools, agencies, and families on effective and evidence-based practices for preparing youth with IDD for community employment ○ service coordination between DRS and DDS, long-term supports available and contract requirements • Better equipping school personnel to utilize transition services and plan for meaningful lives for students with IDD after graduation • Better equipping providers of employment services on how to best support young adults with IDD • Providing ongoing training to community providers, schools, agencies, and families on effective and evidence-based practices for preparing youth with IDD for community employment

		<ul style="list-style-type: none">• Providing ongoing training to community services providers regarding service coordination between DRS and DDS, long-term supports available through Community Integrated Employment Services and requirements for obtaining CIE contracts with DDS.• OMES should support additional funding for expansion of CIE services to meet the increasing demands• DDS requiring each community provider with a DDS contract to obtain a CIE contract to further encourage and support integrated employment• Develop strategies in increase collaboration between agencies represented on the council• Increasing awareness about benefit planning and assistance programs that assure needed benefits are protected• Increasing assistive technology training and support services• Developing standards for day programs• Expanding career technology center capacity in vocational training programs for students with disabilities• Expand autism spectrum disorder services• Improve access to and expand services for assistive technology<ul style="list-style-type: none">○ Increasing competency-based assistive technology training for early intervention programs○ Increasing pre-service assistive technology coursework for professionals○ Increasing the use of short-term loan programs as a part of the selection process to ensure decision-making is data-driven prior to purchase of assistive technology
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Appendix C. 2011-2017 Needs Assessment Results

Oklahoma DDSD Waiting List Study 2011⁶⁶

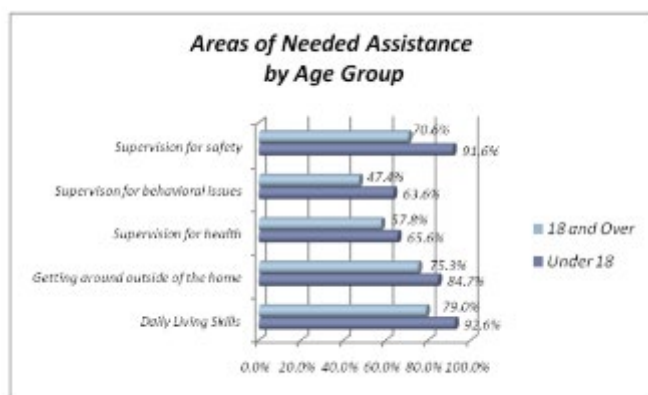
In March 2011, *Analyze This!* conducted a needs assessment on behalf of DHS and the Oklahoma Developmental Disabilities Council. This assessment found that the greatest area of need was assistance with daily living skills. For the under 18 age group, assistance was needed in supervision for safety, getting around outside of the home, and health related assistance. One of the highest reported percentages of need for applicants in both age groups was for case management services. Lesser needed services included major medical services and major or minor adaptations to the home. “For the most part, the study found that most of the applicants on the waiting list need less in terms of amount and intensity of services than they need in terms of information, advocacy and support. Many family members interviewed during the course of this study simply did not feel they were getting the information and financial assistance they needed to care for their family member on the waiting list.”⁶⁷

The percentages of individuals who reported having urgent needs for services was small across all service categories. The highest percentage of those who needed an urgent service was for children in the areas of professional services. For those over 18 who did report an urgent need, it was typically for case management or vocational or day services. Supports within the family home was another common area of need reported by respondents.

When asked about existing services, almost 80 percent of children reported receiving some services through their school system. The overwhelming majority of respondents in all age

groups were not receiving services through the Department of Rehabilitative Services.

Chart 07: This chart shows the areas of need for applicants under and over 18 years old.



Approximately two-thirds of the applicant’s annual family incomes were \$30,000 or less and almost 30 percent had annual family incomes of less than \$15,000. The study found that around 59 respondents out of 800 surveyed reported no longer needing services. Of those, 37 percent reported receiving services elsewhere as the reason, but it does not appear that a follow-up question was asked to determine where and what those services were.

⁶⁶ *Analyze This!*, March 2011, “Oklahoma DDSD Waiting List Study 2011”

⁶⁷ *Analyze This!*, June 2013, “Oklahoma DDSD Waiting List Study Follow-Up 2013”

Recommendations from this 2011 study included more intensive training for data entry personnel maintaining the information for people on the waiting list.

The major conclusion drawn from this study was that most of the families were not in urgent need of services, most families' needs were modest; help with obtaining needed therapies and equipment, help with daily living skills, financial assistance and assistance with minor medical services, help finding day programs and services after from school, planning a future for their child or family member.

Oklahoma DDSD Waiting List Study 2013⁶⁸

Analyze This!, the same company who conducted a needs assessment via surveys with Waiting List persons, conducted a follow-up with some families who had participated in the survey in 2011 with the intent of gaining a richer understanding regarding family experiences. In March 2013, in-person interviews were conducted for three months with 71 prior survey respondents.

Approximately 93 percent of applicants whose family members participated in these interviews lived at home with their families at the time of this study.

Families who reported a household income below \$30,000 were significantly more likely to report feeling overwhelmed a lot of the time. Almost 75 percent of respondents said they need help getting needed services and 78 percent reported the need help accessing the system. Over 90 percent of respondents reported that they would benefit from having another professional to help them figure out the service and resources system. For the most part the study found that most of the family members of those on the Waiting List need less in terms of amount and intensity of services than they need in terms of information, advocacy, and support.

Families caring for a child under age 18 were more likely to report the need for technical supports, usually in the form of equipment (adaptive, learning, or communication).

This 2013 study reaffirmed the findings and recommendations from the 2011 study. Other suggestions made at the time of this 2013 report included:

- to have well-trained, dedicated personnel to be there to inform families as they enter the Waiting List;
- to maintain lists of community resources available to families while on the Waiting List, and;
- to answer and return phone calls to these families throughout the process.

Needs Assessment for Individuals with Intellectual and Development Disabilities: A Summary of the Findings⁶⁹

In August 2017, the DHS Office of Performance Outcomes and Accountability produced a report on survey findings regarding a needs assessment for persons who were waiting. As of June 2017, there were approximately 7,500 persons waiting. **Their wait time was approximately eleven years before receiving services.** The report found it was not uncommon for Waiting List

⁶⁸ *Analyze This!*, June 2013, "Oklahoma DDSD Waiting List Study Follow-Up 2013"

⁶⁹ Department of Human Services, August 2017, "Needs Assessment for Individuals with Intellectual and Developmental Disabilities: A Summary of the Findings"

families to have unmet needs, especially assisting with finding activities to do during the day, transportation, and receiving help with personal care and medical care. Families expressed the needs for services to be delivered soon, a desire to receive enhanced communication from DDS, and frustration with how disabled individuals are treated by the State. “Families simply do not know what Medicaid Waiver services will provide.”⁷⁰ Many families struggle to identify both formal and information resources in their communities and many primary caregivers are experiencing stress and need more respite opportunities. Most persons on the Waiting List live in and around the Oklahoma City and Tulsa metro areas and 91 percent live with family members or friends. The average age of a person waiting was 18.37 years.

There was a wide discrepancy in the use of different programs and/or services respondents were asked about. For instance, while respondents reported that most of the applicants are eligible and currently receiving Medicaid/SoonerCare/TEFRA (81 percent) as well as Supplemental Security Income (SSI) (66 percent), fewer than 10 percent are currently receiving Department of Rehabilitation/Vocational Rehabilitation Services (8 percent, respite services (6 percent), Mental Health Systems of Care/wraparound services (5 percent), or Oklahoma ABLE Tech services (3 percent). For each of these four programs/services, a majority (or near majority) of respondents indicated that they had not applied for or did not know about the service.

When asked about children’s services, respondents indicated that some programs and services are actively being used by at least half of the applicants, including special education services through K-12 public schools (70 percent) and early intervention/SoonerStart (50 percent). The other services and programs had higher proportions of respondents indicate that the applicant has either not applied for or did not know about the service. Services and programs that appear to not be well known include the Lindsey Nicole Henry Scholarship, the Department of Rehabilitation’s School-to Work transition services, Supplemental Security Income – Disabled Children’s Program (SSIDCP), Child Guidance services, and Family Support Assistance Payment.

Services for adults were also measured. Notably from these findings, approximately half of respondents indicated that the applicant had not applied for or did not know about Adult Day services (50 percent) or Career tech/Votech (50 percent). For college disability services, the most selected response was that the applicant was not receiving the service for a reason other than not eligible or not needed.

When asked, 93 percent of respondents reported that the person waiting is still in need of DDS Waiver services. Additionally, 83 percent of respondents reported needing help to receive government services or programs and 63 percent reported they currently receive no informal supports within their community.

Three recommendations came from this Needs Assessment:

- DHS should enhance communication between Waiting List families and DDS;
- DHS should provide a Waiting List family with a Resource Guide to help with the identification of programs and services, and;

⁷⁰ ibid

- DHS should provide more respite opportunities to primary caregivers.

Below are some charts and graphs selected from the 2017 DHS report:

Charts 08, 09, 10, and 11: These charts show responses to various questions on the 2011 Needs Assessment of the Waiver Waiting List.

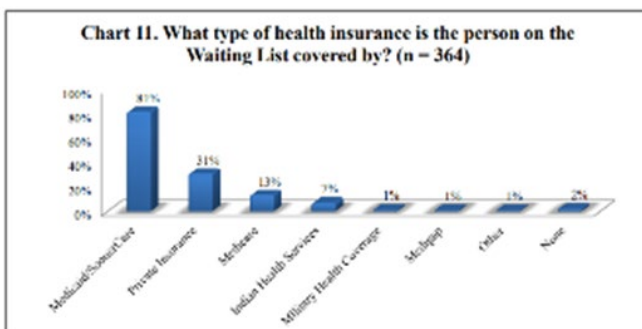
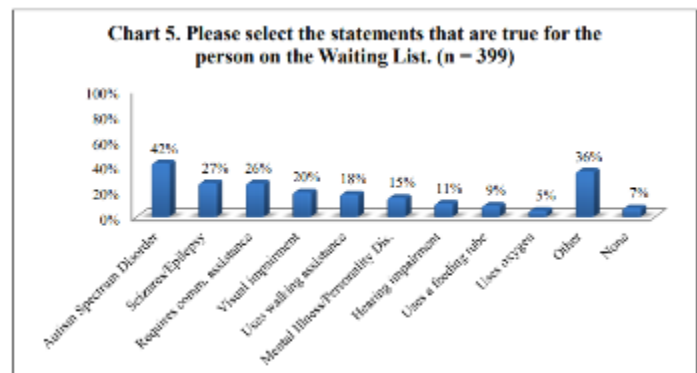
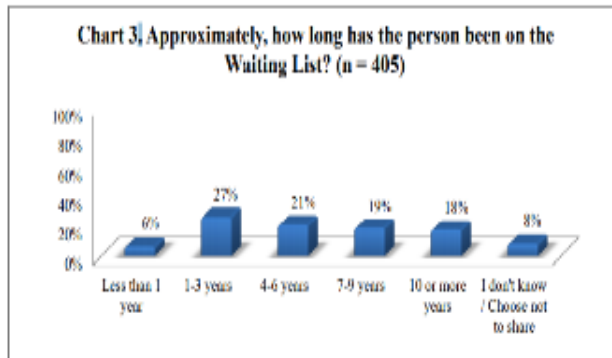


Table 2: What is the total household income/annual income for the person on the Waiting List?

	Applicants Under 18 Years		Applicants 18 Years or Older	
Income	#	%	#	%
Under \$15,000	69	32%	163	90%
\$15,000 - \$29,999	41	19%	7	4%
\$30,000 - \$44,999	46	21%	1	1%
\$45,000 - \$59,999	18	8%	1	1%
\$60,000 - \$74,999	9	4%	0	0%
\$75,000 - \$89,999	3	1%	0	0%
Over \$89,999	11	5%	0	0%
I don't know/Choose not to share	19	9%	10	5%

Oklahoma Department of Human Services Priority of Need Analysis and Screening Tool⁷¹

In 2015, the Governor's Blue Ribbon Panel on Developmental Disabilities recommended establishing a system to prioritize needs as a more effective and responsible way to provide services to Oklahomans with developmental or intellectual disabilities. **The current system considers only the application date and was not reflective of a person's needs.** The Executive Order created a council to analyze how best to prioritize the waiver waiting list so that need and urgency of care would be considered in ordering the list rather than just application date.

In 2017, the OU Center for Public Management was solicited to conduct research and draft a screening and prioritization tool for DHS to analyze the needs of applicants on the Waiting List. In response, a draft tool was developed to address issues such as urgency of need, home

⁷¹ University of Oklahoma Center for Public Management, September 2017, "Oklahoma Department of Human Services Priority of Need Analysis and Screening Tool"

environment, needed supports, caregiver capability and client health to compare support or assistance needed in comparison to peer applicants.

The OU Center for Public Management researched and conducted a comparative analysis of state prioritization tools from four states, Missouri, New Jersey, Pennsylvania, and Utah.

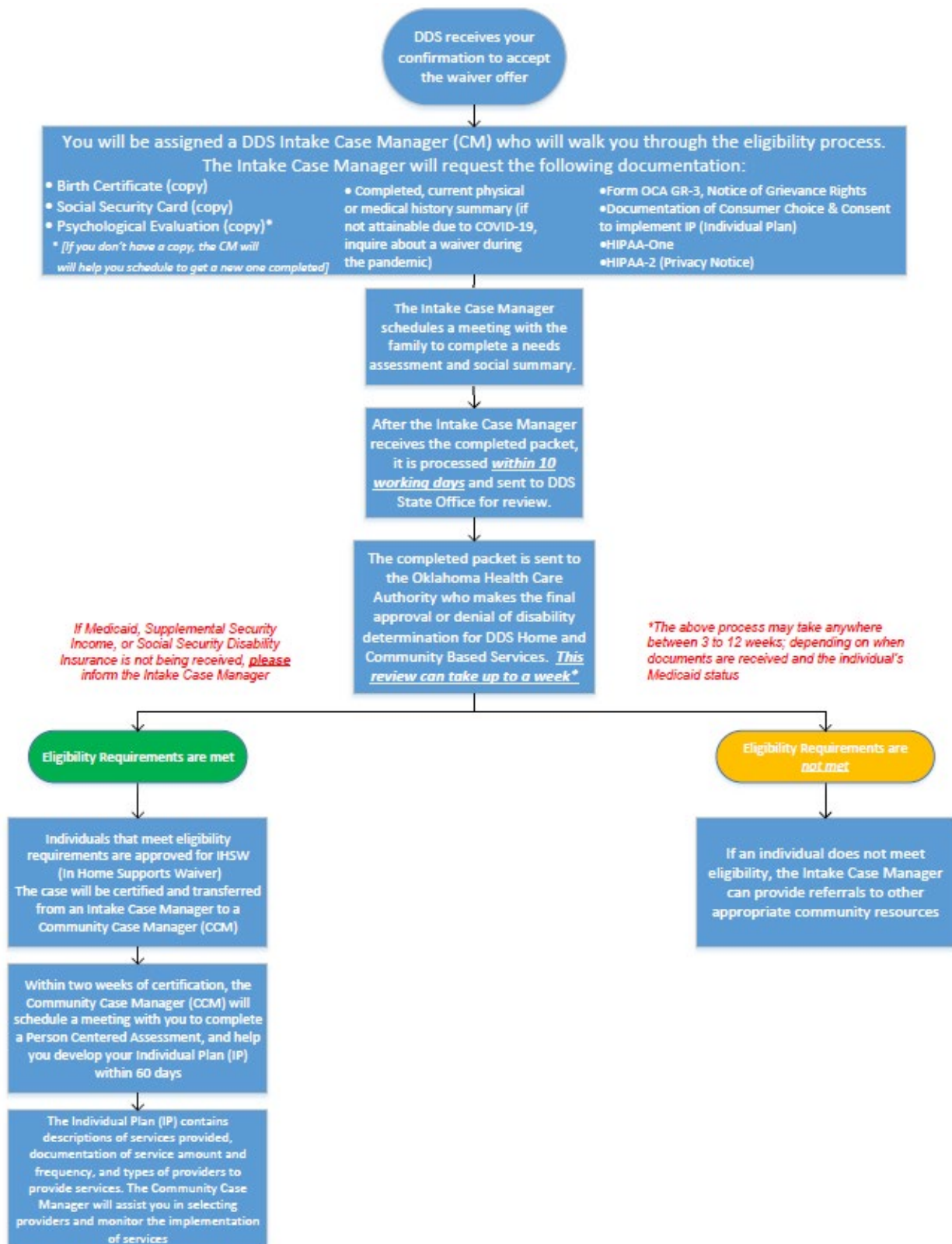
Guiding principles were identified as best practices to be used by Oklahoma in designing an assessment tool including:

- A more comprehensive assessment offers a greater opportunity for population segmentation,
- The assessment should generally assess the needs of the applicant, the use of resources to meet those needs, the stability and availability of the caretaker, and overall health risk,
- The assessment should be targeted towards being administered by intake staff and not be designed as self-service for applicants or caretakers,
- The assessment should be an online form with centralized scoring, and
- Testing will need to be conducted for usability, validity, and reliability.

The Needs Assessment tool developed by OU identified areas of urgency, home environment, needed supports, caregiver capability, and client health. The assessment developed was designed to rank based on a set of criteria and on how much support or assistance the individual needed at that time in comparison to peer applicants. The new assessment tool was then tested among a limited group of potential clients from the Waiting List.

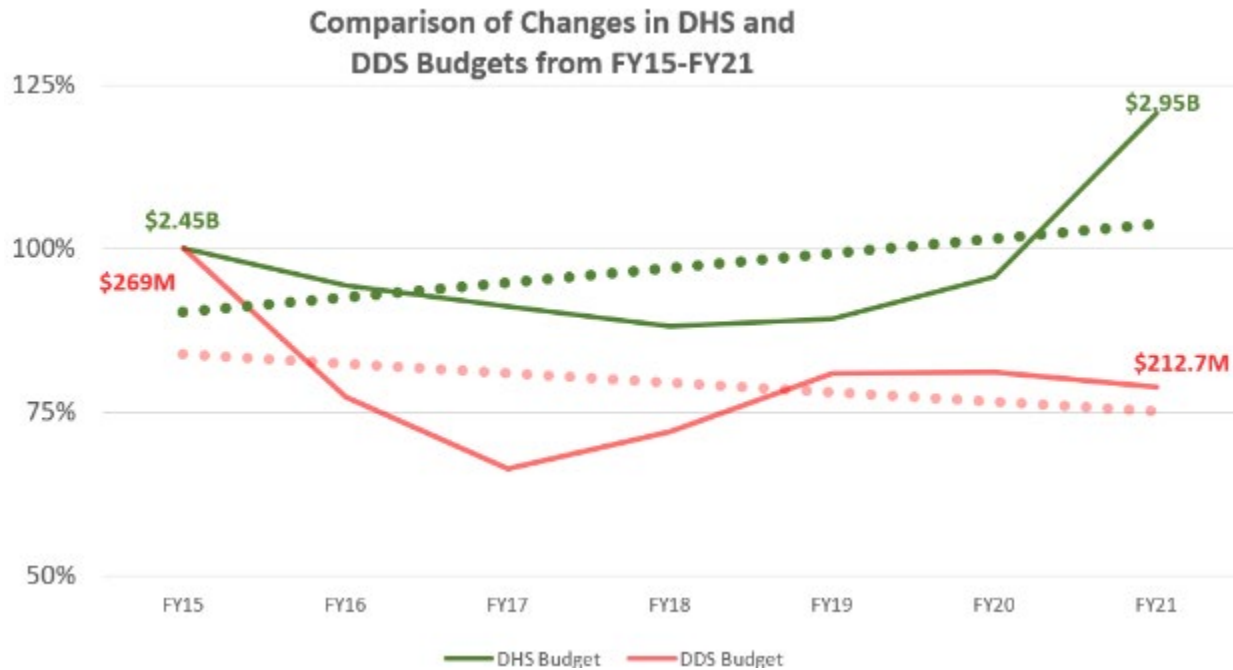
Four variables were found to have been statistically significant predictors of need: age, presence of emergency situations, household support, and medical assistance. For the age variable, the study found that the greater need is present with younger individuals with disabilities. Typically, when a person had a higher score for questions asked to assess any emergency situations, their total need score was higher. An increased number of hours of household support required typically meant an increased overall need score for the person with a disability and is reported as a correlation between time and need. Finally, increased caregiver time spent providing medical assistance led to an increase total need score for the individual with a disability.

Appendix D. Waiting List Flow Chart, From Identification for Services to Placement Into Community and In-Home Services Waivers.



Appendix E. Gap Between the DDS Apportionment of DHS Budget Since FY2012

Chart 12: This chart shows the relative percent change of DDS and DHS budgets from FY15 through FY21



Source: Legislative Office of Fiscal Transparency, information from historical DHS budgets

Appendix F. FY 2015 Legislative Request for Information (LRFI) #3: Office of Community Living – Summary

Figure 13: Introduction paragraph to Colorado's LRFI

December 2015

Introduction

This LRFI asked the Department to report on its plans, timeline and budget to implement the recommendations of the Community Living Advisory Group (CLAG), Colorado's Community Living Plan (response to the Olmstead decision), and the federal rule that sets forth requirements for home- and community-based services (79 CFR 2947). The response includes information about plans and timeline, but not budget because the Department cannot commit to any future budget or legislative action outside of the statutorily authorized budget and legislative process. The work plans described below are a "living" plan that will need to be updated regularly.

For full report, follow subsequent link:

[Fact Sheet TITLE \(colorado.gov\)](#)

Appendix G. Background of Waivers Offered by Oklahoma

OHCA operates the **Medically Fragile Waiver**, a program that provides an alternative to placement in a hospital or skilled nursing facility for Medicaid eligible persons who meet institutional level of care requirements and have a chronic physical condition that results in dependency on medical technology.⁷²

The Oklahoma Human Services Department manages the ADvantage Waiver through the Community Living, Aging and Protective Services division. The **ADvantage Waiver** program provides alternatives to placement in a nursing facility and serves frail elderly and adults with physical disabilities age 21 and over who do not have intellectual disabilities or a cognitive impairment.⁷³

DHS also manages four waivers for persons with intellectual or developmental disabilities through their Developmental Disabilities Services division, which offers an array of community services for individuals with developmental disabilities and their families.⁷⁴ A waiver is a funding mechanism which allows the state to offer community-based services as an alternative to institutional services.⁷⁵ To be eligible for the HCBS waivers a person must be financially eligible for Medicaid, have a diagnosed intellectual disability, need institutional level of care, and meet other waiver-specific criteria.⁷⁶ The **Homeward Bound Waiver** was designed to create community-based services for adults certified as the Plaintiff Class in the 1987 Homeward Bound case.^{77 78}

The **Community Waiver**, approved in 1988, includes a comprehensive array of services for persons with intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disabilities. Services for the Community Waiver include residential, employment, and habilitation service and supports for individuals three years of age and older.⁷⁹

The **In-Home Supports Waivers** were created in 1999 as capitated waivers to allow families to select services needed for persons with intellectual disabilities to remain in their homes. This waiver is separated into a waiver that serves children ages 3-17 and a waiver that serves adults.

⁷² [The Medically Fragile \(oklahoma.gov\)](https://www.oklahoma.gov/ohca/medically-fragile-waiver)

⁷³ [ADvantage Waiver \(oklahoma.gov\)](https://www.oklahoma.gov/ohca/ad-advantage-waiver)

⁷⁴ [Program Information \(oklahoma.gov\)](https://www.oklahoma.gov/ohca/program-information)

⁷⁵ [Program Information \(oklahoma.gov\)](https://www.oklahoma.gov/ohca/program-information)

⁷⁶ Overview of Waivers and Waiting List, Oklahoma Human Services, October 2020

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ Ibid.

Appendix H – Federal Provisions/Olmstead Decision

Olmstead Decision Background:

In 1999, the U.S. Supreme Court ruled in *Olmstead v. L.C.* that people with disabilities have a qualified right to receive state funded supports and services in the community rather than in institutional settings when certain criteria is met. In the case, two women from Georgia with diagnoses of mental health conditions and intellectual disabilities who were eligible for state-provided in-home and community-based services were instead frequently transported to the state's mental health hospital for care. In the Olmstead decision, the Court held that by not providing access to in-home and community-based services and confining the women to a hospital setting, the state had discriminated based on disability thus violating the Americans with Disabilities Act.⁸⁰

Olmstead Enforcement and Impact on States:

Following Olmstead, states have been subject to litigation regarding legal enforcement of the ruling. The U.S. Department of Justice and more than fifty individuals and advocacy groups have sought legal action against states on behalf of individuals at risk of institutionalization who were seeking Home and Community Based Services (HCBS) in their community.⁸¹

Enforcement of the Olmstead decision led to changes to Louisiana's HCBW program. In 2016, the U.S. Department of Justice (DOJ) concluded Louisiana had failed to provide the option for HCBS to eligible individuals with mental disabilities and instead utilized more costly long-term nursing home settings.⁸² In a subsequent settlement with the DOJ, the state agreed to reform its HCBW program. Louisiana began to proactively screen certain individuals in nursing homes to determine if they would be eligible for HCBS.⁸³ In addition, Louisiana reformed its waiver application process to a "Tiered Waiver" plan that prioritizes need and urgency for individuals seeking HCBS services, instead of administering services on a "first-come, first-serve" basis. This change in process resulted in all individuals with urgent need receiving HCBS as of July 2018.⁸⁴

According to the U.S. Department of Health & Human Services, the Oklahoma State Department of Human Services resolved five documented cases regarding individuals who did not receive full medical and social services guaranteed under the Olmstead decision.⁸⁵

⁸⁰ [Olmstead Decision \(olmsteadrights.org\)](https://olmsteadrights.org/)

⁸¹ Carol Beatty, "Implementing Olmstead by Outlawing Waiting Lists," Tulsa Law Review, Volume 49, Issue 3, Art. 6.

⁸² Michael Cronin, *United States v. Louisiana* (2016), University of Michigan Law School: Civil Rights Litigation Clearinghouse, March 3, 2021, <https://www.clearinghouse.net/detail.php?id=15937>.

⁸³ Ibid

⁸⁴ Louisiana Department of Health, "New approach to home and community based services ends wait for thousands of citizens with developmental disabilities," July 16, 2018, <https://ldh.la.gov/index.cfm/newsroom/detail/4687>; Louisiana Department of Health, "Update: Louisiana Department of Health eliminates waiting list for those with developmental disabilities," April 30, 2019, <https://ldh.la.gov/index.cfm/newsroom/detail/5137>.

⁸⁵ U.S. Department of Health and Human Services, "OCR Olmstead Enforcement Success Stories: Preventing Discrimination Against People with Disabilities in Health Care and Social Services," <https://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/olmstead/index.html>.

Appendix I. –DDS Case Manager Job Description (Source: DHS)

TITLE: Case Manager III

DHS CODE: 2737

ADOPTED: Oct. 18, 2019

REVISION DATE:

GENERAL FUNCTION

Positions in this job family are assigned responsibilities related to providing direct and indirect casework services to individuals with intellectual and/or developmental disabilities and their families.

ESSENTIAL ACCOUNTABILITIES

Lead workers or back-up supervisors to lower-level case managers.

Provides training and mentoring in caseload principles and practices and ensuring compliance with federal and state regulations and agencies policies, procedures and practices.

Assigned responsibilities at the full performance of all levels in managing a caseload of consisting of all disability areas.

Acts as an advocate for individuals to ensure community presence and participation.

Support the individual and family/guardian/significant others to make life decisions which lead to independence and interdependence.

Serves as team leader of the Interdisciplinary Team (IDT).

Ensures the development, implementation, monitoring/evaluation and modification of the IHP IP for desired outcome and developing the plan of care, including the development of individualized treatment plans.

Coordinates the development, implementation and modification of the Individual Plan (IP); monitors the IP and plans of care for desired outcome.

Coordinates guardianship procedures for adult individuals when a need is identified.

Assists Level I and II Case Managers by furnishing information concerning case management practices, standards, rules and regulations and community resources, providers and programs.

Serves as a resource individual for Level I and II Case Managers in providing information concerning specialized programs, services and treatments.

Participates on committees at both local and state levels to formulate policies and procedures and to promote community awareness.

COMPLEXITY OF SKILLS AND ABILITIES

Knowledge of case management methods, principles and techniques

Knowledge of types of intellectual and developmental disabilities represented within the caseload

Knowledge of types of providers and services available for individuals with intellectual and/or developmental disabilities

Knowledge of problem solving and mediation techniques, and of adaptive communication techniques and nonverbal communication.

Knowledge of the behavioral sciences and allied disciplines involved in the evaluation, care and training of individuals with intellectual and/or developmental disabilities.

Ability to conduct group and individual training sessions

Ability to manage a caseload of clients with intellectual and/or developmental disabilities

Ability to work cooperatively and effectively with other professionals in a team situation; to collect and analyze information

Ability to make decisions relating to services provided to individuals

Ability to develop a logical and practical individual plan for individuals with intellectual and/or developmental disabilities

Ability to evaluate the progress of individuals and the quality of their habilitation programs; to communicate effectively; and to manage and prioritize work based on the needs of the caseload.

Competencies required at this level include business etiquette, oral communications, written communications, stress management, flexibility and adaptability, customer service, conflict resolution, external/global awareness, legal concepts, ethical concepts, planning and evaluating, and measurements and assessment skills.

MINIMUM QUALIFICATIONS

Education and Experience requirements at this level consist of a bachelor's degree in a human services field* and three years of professional experience working with individuals with intellectual and/or developmental disabilities in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, program coordination, nursing or a closely related field.

A bachelor's degree and three years of professional experience in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, program coordination, nursing or a closely related field and one year experience working with individuals with intellectual and/or developmental disabilities.

Possession of a valid permanent Oklahoma license as approved by the Oklahoma Board of Nursing to practice professional nursing and three years of professional nursing experience working directly with individuals with intellectual and/or developmental disabilities.

**For purposes of the Case Manager job family "a bachelor's degree in a human services field includes any degree from an accredited college or university except for a degree in a physical, natural or biological science or mathematics.*

NOTE: Applicants must be willing and able to perform all job-related travel normally associated with this position. Applicants must be willing to work extended hours including scheduled non-business times such as evenings and weekends.

Some positions may be required to be on-call twenty-four hours a day, seven days a week.

Appendix J – DHS Divisions and Services

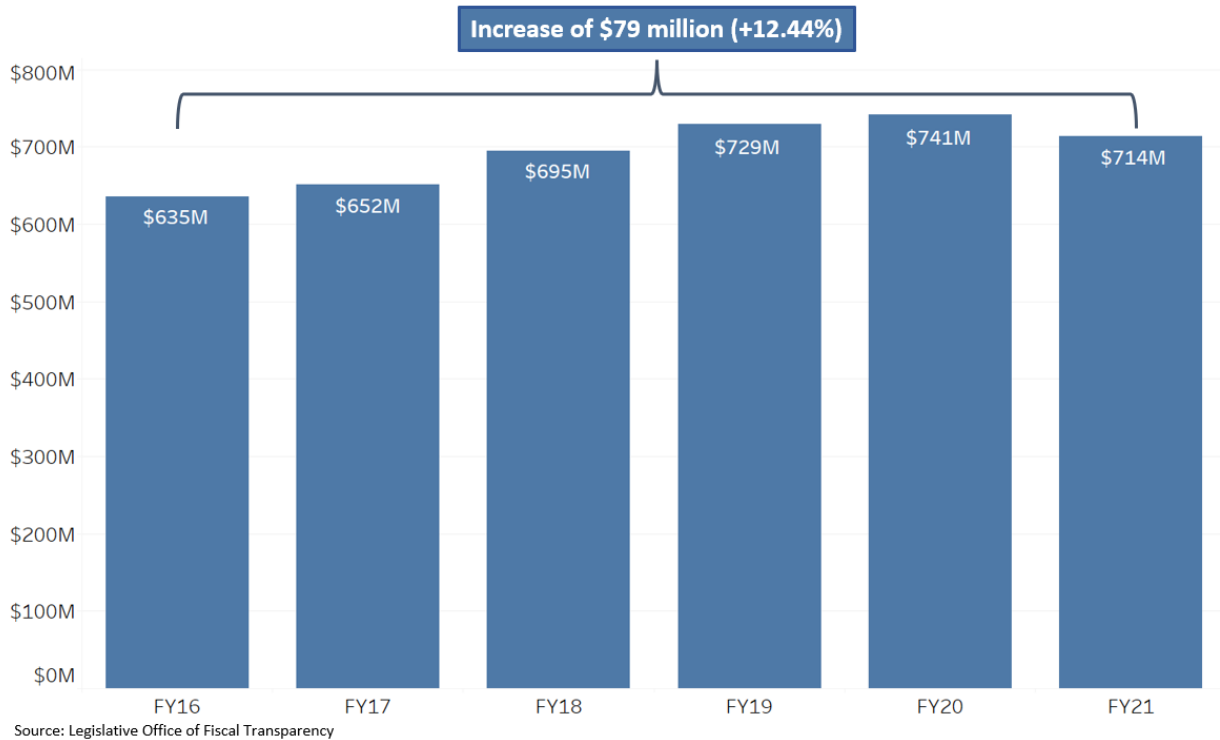
Figure 14: This figure shows the departments and divisions within the Oklahoma Department of Human Services.



Source: Legislative Office of Fiscal Transparency's creation

Appendix K: State Appropriations for DHS

Chart 13: This chart shows the State appropriations to DHS from FY16 through FY21. This information is pulled from Senate Appropriation Highlight reports.



Appendix L: Community & In-Home Waiver Services Provided by Category FY16-FY21

Table 12: Services Provided to the Community Waivers from FY16 to FY21

	FY16	FY17	FY18	FY19	FY20	FY21
Type of Service	Community					
Direct Support	\$123,359,967	\$127,988,817	\$123,957,952	\$134,560,533	\$143,437,066	\$175,493,185
Group Home	\$22,045,391	\$22,004,969	\$21,741,285	\$24,378,487	\$26,109,113	\$29,368,413
Employee Training Specialist	\$22,717,413	\$23,158,143	\$22,420,677	\$22,993,260	\$20,251,658	\$18,150,879
Behavioral Health	\$5,618,300	\$6,020,549	\$5,789,032	\$5,881,835	\$6,063,193	\$6,320,195
Transportation Services	\$5,497,341	\$5,525,414	\$5,248,113	\$5,537,904	\$5,153,182	\$4,025,023
Medical Supplies/DMEPOS	\$3,461,895	\$3,596,132	\$3,352,230	\$3,500,461	\$3,537,144	\$2,238,248
Nursing Services	\$3,502,883	\$3,525,237	\$3,424,013	\$3,157,414	\$3,279,361	\$3,515,408
Specialized Foster Care/ID Services	\$2,836,885	\$2,623,700	\$2,480,213	\$2,533,816	\$2,533,629	\$2,865,979
Homemaker Services	\$1,824,833	\$1,728,675	\$1,660,934	\$2,019,834	\$1,847,818	\$1,596,274
Prescribed Drugs	\$1,348,429	\$1,317,353	\$1,424,416	\$1,541,067	\$1,819,821	\$2,106,201
Therapy Services	\$1,216,214	\$1,351,001	\$1,456,273	\$1,596,168	\$1,706,097	\$1,786,487
Adult Day Care	\$1,497,253	\$1,569,130	\$1,556,100	\$1,848,895	\$1,621,631	\$1,174,418
Physician	\$1,383,268	\$1,353,126	\$1,299,412	\$1,180,094	\$1,312,376	\$1,046,489
Dental	\$522,092	\$522,061	\$478,922	\$579,966	\$521,643	\$505,246
Nutritionist Services	\$548,653	\$483,832	\$493,896	\$510,671	\$516,438	\$470,311
Respite Care	\$45,277	\$35,033	\$25,947	\$49,575	\$144,998	\$288,260
Architectural Modification	\$118,222	\$100,898	\$118,734	\$171,544	\$140,737	\$72,134

Source: Legislative Office of Fiscal Transparency, OHCA data

Table 13: Services Provided to the In-Home Waivers from FY16 to FY21

	FY16	FY17	FY18	FY19	FY20	FY21
Type of Service	In-Home Support					
Direct Support	\$18,455,125	\$18,847,362	\$17,827,855	\$18,650,893	\$19,790,831	\$20,895,936
Employee Training Specialist	\$3,835,246	\$3,660,831	\$3,472,791	\$3,405,801	\$3,031,552	\$2,523,505
Adult Day Care	\$793,885	\$887,010	\$827,867	\$852,093	\$739,820	\$554,932
Transportation Services	\$636,625	\$676,049	\$613,141	\$662,205	\$620,209	\$513,349
Medical Supplies/DMEPOS	\$656,332	\$511,702	\$505,413	\$474,402	\$612,123	\$347,738
Prescribed Drugs	\$412,849	\$388,248	\$364,267	\$425,424	\$394,980	\$535,213
Behavioral Health	\$205,627	\$227,903	\$213,055	\$213,357	\$237,195	\$271,259
Homemaker Services	\$179,830	\$158,178	\$140,794	\$180,803	\$149,720	\$108,032
Dental	\$100,258	\$97,133	\$86,957	\$98,369	\$110,401	\$113,722
Therapy Services	\$63,296	\$73,253	\$75,158	\$68,535	\$84,107	\$113,807
Architectural Modification	\$40,961	\$6,594	\$15,072	\$5,671	\$24,178	\$4,444
Physician	\$46,314	\$45,260	\$34,977	\$22,582	\$23,734	\$14,348
Nutritionist Services	\$3,240	\$4,081	\$2,388	\$1,600	\$869	\$5,033
Group Home	\$0	\$0	\$0	\$0	\$0	\$0
Nursing Services	\$6,635	\$3,115	\$1,288	\$0	\$0	\$0
Respite Care	\$272	\$0	\$0	\$0	\$0	\$5,096
Specialized Foster Care/ID Services	\$0	\$0	\$0	\$0	\$0	\$0

Source: Legislative Office of Fiscal Transparency, OHCA data

Appendix M: List of Services Members Receive While on DDS Waiting List

Subsequent list are the services provided to members while waiting on the DDS Waiting List. List provided by DHS and is order of most request/utilized to the fewest:

- Medicaid services
- Social Security Payments
- Supplemental Nutrition Assistance Program (SNAP)
- Family Support Subsidy (FSS)
- SoonerCare for children with severe medical needs (TEFRA)
- Shelter workshop
- Community integrated workshop
- Aging adult day (state funded)
- Respite (state funded)
- State Plan Personal Care
- Group home
- Omnibus Budget Reconciliation Act 1987 (ORBA), further known as the “Nursing Home Reform Act of 1987”
- Assisted living
- Adult day care

Appendix N: Washington and Oregon Medicaid Agency and Operating Agency Roles

Washington State CMS application depicting roles between all agencies and entities involved in HCBS Waiver process.

Application for 1915(c) HCBS Waiver: WA.0411.R03.03 - Feb 01, 2019 (as of Feb 01, 2019)

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function.

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

Oregon CMS application depicting roles between all agencies and entities involved in HCBS Waiver process.

Application for 1915(c) HCBS Waiver: Draft OR.008.06.02 - Apr 01, 2019

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In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

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

Appendix O: Agency Responses

- LOFT's response to DHS response, October 25, 2021
- DHS response, October 5, 2021

October 25, 2021



LOFT's comments on the response from the Oklahoma Department of Human Services

As part of LOFT's protocol, agencies are granted the opportunity to respond to the evaluation report and findings. For this priority program evaluation, LOFT examined the Department of Human Services' (DHS) management of Medicaid waiver programs designed to serve developmentally disabled citizens.

Portions of DHS' response warrant further clarification and correction, which will be addressed. With this response, LOFT seeks to address questions of fact, and not differences of opinion.

Scope of Project and Evaluation Process

Priority program evaluations provide a detailed, multi-faceted review of State programs. Over the course of several months, LOFT researched both state and federal rules, regulations, and guidance, evaluated sources of funding, met with agency representatives directly engaged with administering the Waiting List, spoke with stakeholders receiving waiver services as well as those waiting to receive services, and examined other states' effort and progress in administering the same type of waivers. For this evaluation, LOFT examined **only** the three waivers for which there is a waiting list for services. All three programs are administered by DHS.

The scope of this evaluation sought to quantify the resources required to serve those waiting for waivers, examine past efforts to move those waiting for waiver services into receiving services, and identify opportunities for the State to better serve those in need of waiver services.

LOFT originally engaged with DHS for data and information requests relevant to the evaluation. After limited communication and a series of delays in DHS's fulfillment of these requests, LOFT began working with the Health Care Authority to obtain and verify data. While DHS is the operating agency for the waivers under review, Federal provisions place authority of the programs with the Health Care Authority. Additionally, wherever possible, LOFT independently verified data with the Federal Centers for Medicare and Medicaid Services (CMS). LOFT strives to minimize an agency's time and resources, requesting as much pre-existing data or information as possible. The only DHS-provided dataset used for this report is raw data pertaining to the composition of the waiting list.

Much of DHS's response to LOFT's report is directed at the evaluation process, in which the agency chose to not be fully engaged. Additionally, the agency highlights differences in data that could have easily been resolved with communication. The mission of LOFT is to provide the Legislature with the best possible information from which to make informed policy and budgeting decisions. In this role, LOFT also seeks to identify opportunities for improved outcomes. LOFT contends the Legislature is best served when an agency cooperates with this process and is united in these goals.

LOFT's response to claims of inaccuracy within report:

1. DHS' response contends LOFT does not accurately describe conditions for waiver eligibility. LOFT provides this definition in the first sentence of the report's executive summary, again in the first paragraph of the report's introduction (page 1), and provides a table detailing eligibility criteria for each waiver on page 2 of the report.

2. DHS contests LOFT's description of individuals who transitioned into waiver services as "relatively flat," citing that 492 people have moved into waivers between FY19 to FY21. LOFT maintains this movement – 3.4 percent per year – is relatively flat.
3. DHS claims the current needs assessment "could not be more materially different than the assessment being conducted..." based on the percent of population being assessed and the navigation tools that will be provided after the assessment. LOFT maintains that the type of data being collected is similar to that of past assessments. DHS asserts the information will be *delivered* differently. LOFT recognizes the usefulness of assessments but contends the more significant factor is how that information will be used to provide services.
4. DHS claims there is no correlation to state appropriations and the agency's 5-year waiver plan. LOFT acknowledges the 5-year plan is not set by state appropriations; however, it is state dollars that secure the federal matching funds, and the expected total funding informs how many waiver "slots" can be funded over that period.
5. DHS claims LOFT misinterprets data about the agency's capacity to serve children, based on the number of child waiver slots budgeted for in the agency's plan. LOFT reported accurate information about children served relative to budgeted capacity to serve this demographic. With its response, DHS affirmed its intent to not serve the majority of child In-Home Waivers due to current wait times and incorrectly dismisses the relevance of the budgeted waiver slots in the agency's service plan. Waiver slots represent the maximum number of members that can be served at a given point in time. As DHS cites in its response, "the number of persons to be served should be based on a careful appraisal of the resources a state has." The number of planned waivers informs the budgeted plan. According to federal guidelines, the 5-year plan is a state's best estimate at capacity to serve each waiver and states are obligated to serve the plan to capacity.
6. DHS contests LOFT's conclusion that DHS lacks a strategic plan for serving people waiting for services. While DHS articulates goals and objectives, the agency provides no action plan for how to accomplish them.
7. With its response, DHS provided new information about the percentage of members that move into capped service waivers. LOFT has adjusted calculations throughout the report to reflect this information.
8. Throughout its response, DHS response ascribes motives to LOFT's report, including an attempt to present the agency in a negative light, to "mislead," or to "sensationalize" data. LOFT presents objective data and information, without commentary or opinion. LOFT achieves this, in part, by confirming data with multiple sources and stakeholders, including oversight entities and federal authorities, when applicable.
9. DHS' response claims use of quotes obtained from written communications received by LOFT from DHS is an "inappropriate use of transparency." It is LOFT's practice to document and substantiate all information provided during the course of an evaluation.
10. DHS claims Chart 1 on page 3 is incorrect, with LOFT understating persons served by waivers. DHS provides figures from the agency's annual reports, but includes totals served by the Homeward Bound waiver, which was not a part of this evaluation. As stated in the first page of this report and repeatedly throughout, LOFT examined only the three waivers for which there is

a waiting list for services: the Community Waiver, the In-Home Services Waiver for Children, and the In-Home Services Waiver for Adults.

11. On page 4, under “recent actions,” DHS contests LOFT’s presentation of the wait list figures due to not expressly reporting the number of new applicants added to the list in FY19. DHS presents a one-year snapshot of the list, while LOFT presents the year-over-year change in the list. LOFT’s report presents net numbers, inclusive of additions and removals, from FY19 to FY20.
12. DHS’s response provided an unsourced chart of Oklahoma’s historical blended FMAP. LOFT has updated the FMAP data to reflect the most recent figures, as provided by the State’s Medicaid agency, which receives the Federal matching funds. Accordingly, LOFT has updated Chart 4 on Page 13. The table now reflects a net decline of \$13.4 million in the state portion of funds dedicated to the Community and In-Home Waiver Program from FY16 to FY21.
13. Chart 5 on page 14 has been updated to reflect new data regarding the number of Medicaid providers dedicated to providing DDS waiver services. The updated figure, provided by the Health Care Authority, is greater than the number provided by DHS in its response. This discrepancy is based on DHS reporting “distinct” vendors while OHCA reports all vendors, including multiple locations served by one parent vendor.
14. DHS asserts the information presented in Table 5 on Page 15 presents an inaccurate flow of funding. Rather, as described in the paragraph leading into the table, it depicts the three options for stabilizing provider rates.
15. In the section titled, “Agency-Perceived Challenges,” LOFT sought to verify areas identified by the agency as obstacles. DHS’s response claims LOFT does not understand the future IT plan of the agency. In this section of the report, LOFT acknowledges the agency’s plans to upgrade information technology. However, the key takeaway from this section is LOFT’s observation that the agency’s current system should not be limiting the agency’s functionality. LOFT observed the agency’s data system firsthand, by a staff member with direct experience with a similar system. For the purpose of the report, LOFT sought to understand both the limitations and functionality of the system to collect and maintain data and information. LOFT maintains its assessment that DHS’ system, while antiquated, is capable.
16. DHS cites a historical interpretation of Medicaid requirements to serve those determined eligible to receive waiver services but does not dispute LOFT’s citation of administrative rules that allow for determining eligibility of a person upon signing up on the Waiting List. DHS claims the current assessment is “a bold and different path forward.” LOFT’s review of the rules from the Center for Medicare and Medicaid Services (CMS) require the State to take such action in order to be in compliance by 2022. While the information provided by DHS is undated, LOFT accessed the hyperlinks referenced and it appears that the guidance provided by the National State Directors Association pre-dates the 2014 guidance by the CMS. LOFT has included a fuller explanation of this guidance on page 17 of the report.
17. DHS claims as inaccurate the percentage of those who died waiting for services, (page 18 of the report). The figures cited by LOFT are from the same data set provided by DHS in its response. The difference in the reported percentage of people who died waiting for services is due to methodology. DHS diluted the data by using all people contacted; LOFT calculated the percentage as the total number of people not placed into services. Regardless of the

percentage, DHS and LOFT are in consensus that 10 of those contacted for services were reported as deceased.

18. In its response, DHS states it administers the program and “OHCA pays the claims.” This statement minimizes the Health Care Authority’s role as the oversight and administrative body that is accountable to the Federal government for proper expenditure of Medicaid funds, establishing program rules, and ensuring compliance. DHS claims the waiver application figure included in the report (Figure 6 on page 20) is “not considered atypical” in that “most states have the majority of boxes checked for the operating agency as well as the Medicaid agency, if they are not the same.” LOFT examined the Medicaid Waiver Application for both Washington and Oregon, two state programs similarly structured as Oklahoma, and found their administrative operating structure to be very different. LOFT has added figures of both states’ waiver application to Appendix N in the report for comparison.
19. DHS challenges the accuracy of the map on page 21 depicting states’ structuring of 1915(c) Waivers, citing 2016 data from the National Association of Medicaid Directors. As appropriately sourced in the report’s footnotes, LOFT obtained data for the creation of this map directly from state applications to CMS, using the most recently available applications (the oldest of which was 2019 data).
20. In response to Table 7 on Page 22 of the report, DHS said it was “inappropriate” for LOFT to use information from both the Health Care Authority and advocacy groups. LOFT’s process is to independently verify data and information provided by an agency, whenever possible. With each report, LOFT also conducts a stakeholder assessment and works to ensure those viewpoints are reflected.
21. Table 10 is based on numbers submitted by DDS in its application to CMS. In its response, DHS stated that each waiver has a 5-year plan for programming, as opposed to being correlated to the next 5 fiscal years. This information has since been verified by LOFT, and table 10 has been updated to reflect the 5-year plan for both the Community Waiver and the In-Home Services Waivers (both adult and child). Regardless of whether using plan year or fiscal year, the data presented in the table demonstrates the agency’s plan to serve just 11.4 percent of those waiting for services over a five-year time frame.
22. On page 30 of the report, DHS contests LOFT’s inclusion of a statement made during the October 6, 2020 entrance conference by the agency’s Chief of Staff that \$5 million in funds would “fix” the Waiting List. This statement was documented by multiple attendees.
23. Last, DHS states throughout its response that it spent “hundreds of hours” furthering LOFT’s understanding of the agency’s waiver programs. LOFT’s records reflect the following time directly engaged with DHS:
 - a. October 6, 2020: Entrance conference meeting lasting **90 minutes**
 - b. October 12, 2020: DHS replies by email to a set of questions resulting from the entrance conference.
 - c. May 24, 2021: DHS responds to an additional request for information from LOFT from April 26, 2021. Of the 27 questions asked, 19 were for pre-existing data, seven of which were fulfilled by the Health Care Authority. DHS replied “N/A” to four questions; three questions were replied to with “no,” one response was a hyperlink, and two responses

did not fully answer the question. LOFT is unable to quantify the agency's time responding to these questions.

- d. June 7, 2021: LOFT contacts the agency to narrow its remaining requests to three items deemed most valuable to the report: financial details about how dedicated appropriations over the last three years have been utilized directly for the Waiting List, and two requests for access to conduct fieldwork.
- e. July 8, 2021: LOFT completes a site visit to conduct fieldwork (to observe data systems and speak with employees) – approximately **2.5 hours**.
- f. August 2, 2021: DHS fulfills the June 7 request from LOFT for information about how dedicated appropriations have been used specific to the Waiting List.
- g. September 27, 2021: LOFT conducts a virtual exit conference with DHS for the purpose of obtaining feedback about the draft version of the report, identifying discrepancies, and verifying data and accuracy of information. The meeting lasts **15 minutes**.



OKLAHOMA
Human Services

Executive Summary

Prior to 1981, individuals with critical developmental or intellectual disabilities were often limited to receiving state-funded support in an institutional setting. Expansion of the Social Security Act provided guidelines to states for meeting those needs outside of institutional care.

Through Home and Community-Based Services Waivers, states have the option of “waiving” certain Medicaid program requirements to tailor services to Medicaid recipients living in their communities. Federal guidelines provide states with broad authority in creating waiver programs, as long as the cost of services provided through the waiver don’t exceed the costs of services in an institutional setting.

When state resources and funding are not available to meet the needs of all those who seek services provided through Medicaid waivers, a “waiting list” is created. There are 5,619 physically or mentally disabled Oklahomans waiting to receive services through a state waiver as of March 2021.

Number of People on Waiting List Grouped by
Number of Years Waiting, as of March 2021



The 1999 U.S. Supreme Court Olmstead decision established that those with needs meeting an institutional level of care have the right to receive services within their community, if able.

Home Based Community Waivers are a

DHS Response:
Factually Inaccurate - DDS Medicaid Waivers serve persons with intellectual disabilities or certain persons with related conditions not persons who have physical or mental disabilities.

See Tab A: OAC 317:40-1-1

DHS Response:

Factually Inaccurate - DHS provided LOFT the number of individuals directly funded by the additional state appropriations. From FY19 through FY21, there were 492 individuals transitioned from the waiting list to receiving waived services, with an additional 33 pending.

Finding 1: DHS' Management of the Waiver Program Has Not Led to Substantial Progress Toward the State's Goal of Providing Services to All Those Waiting

The two key drivers of waiting lists are high demand and program limitations, which can include a program's structural design or resources. LOFT found that the number of people moved from Oklahoma's Waiting List into waiver services over the past decade has remained relatively flat, despite the Oklahoma Legislature dedicating almost \$9 million over the past eight years to the Department of Human Services (DHS) for this purpose. LOFT observed no direct correlation between the additional appropriated funds and the actual transition of people moving from the Waiting List into a waiver.

The greatest change in the Waiting List – 2,400 applicants removed in 2019 – was due to purging the names of those who could not be reached or no longer needed services. In evaluating past and current management of the waiver program, LOFT found that DHS's failure to conduct intake assessments of those signing up on the Waiting List limits the agency's understanding of individuals' needs and subsequently, development of a plan to meet them. Proper intake could also determine which of those waiting need immediate services and which are waiting in anticipation of future service needs.

DHS recently contracted for an independent assessment of the needs of

list 15 years ago. Under these conditions, a 5-year-old entering the Waiting List today would likely never receive the In-Home Service Waivers for Children due to the length of the wait time. That child would age out before becoming eligible and would first receive services under the more expensive In-

DHS Response:

Factually Inaccurate - When an individual or family applies, DDS intake speaks with them about their needs and offers local resources if requested. If there appear to be immediate needs, DDS conducts an emergency assessment to possibly pre-empt the waiting list.

DHS Response:

Factually Inaccurate - Prior surveys could not be more materially different than the assessment being conducted by Liberty. Previous surveys were random samples and never covered more than 12% of people waiting at the time of the survey, nor were they as detailed to truly understand the need of people waiting and their families. And last, but certainly not least, they did not provide a formal navigation plan and ongoing services to every person on the WL.

See Tab B: Waiting List Assessments/Surveys Breakdown

The greatest change in the Waiting List – 2,400 applicants removed in 2019 – was due to purging the names of those who could not be reached or no longer needed services. In evaluating past and current management of the waiver program, LOFT found that DHS's failure to conduct intake assessments of those signing up on the Waiting List limits the agency's understanding of individuals' needs and subsequently, development of a plan to meet them. Proper intake could also determine which of those waiting need immediate services and which are waiting in anticipation of future service needs.

DHS recently contracted for an independent assessment of the needs of those waiting for waivers; the sixth assessment to be conducted in approximately a decade. LOFT did not observe key differences between the current and past assessments, nor a strategic plan for how this new information would be used to move those waiting into waivers.

Approximately half of those on the Waiting List contacted by DHS for services are not moved into waiver services. LOFT found that DHS' management of the Waiver Program and lack of case management upon application for a waiver are contributing to inflation of the Waiting List.

*wait time.
That child would
age out before
becoming
eligible and
would first
receive services
under the more
expensive In-
Home, Adult or
Community
Waivers.*

Finding 2: The Ratio of Budgeted Community-Based and In-Home Service Waiver Slots to Members Served is Declining, Despite Increases in State and Federal Funding

States that offer waiver programs submit a plan to the Federal government demonstrating its ability to continually fund any wavier slots. In comparing the number of members served from FY16 to FY20 to the number of waiver slots budgeted for in the agency’s five-year plan, LOFT found that DHS is serving less members than its plan states it can serve. Additionally, LOFT observed a declining percentage of members served over the five-year period when compared to the number of slots budgeted for in the agency’s plan.

The In-Home Service Waiver for Children, which is only available for children aged 3-17, has the lowest utilization rate (or service rate) of all DHS’s Home and Community-Based Waivers. This waiver is currently the most cost-effective Medicaid waiver offered in Oklahoma, yet DHS offers a maximum of 250 waiver slots for this program and for the past three years has served just over half of those slots. 1,890 of those on the Waiting List are between the ages of 3-17.

The Developmental Disabilities Services division (DDS), which administers the Home and Community-Based Waiver Program, is one of seventeen divisions within DHS. DDS has become a diminishing priority within DHS since FY13, based on its budget as an overall percentage of DHS’ budget. LOFT found that increases in Federal matching funds, State appropriations, and an overall increased budget to DHS, have not resulted in serving substantially more people through the Community and In-Home Services Waiver Program.



DHS Response:

Factually Inaccurate – It is wholly inaccurate to say there is an exact correlation to the capacity in a 5-year Waiver that is directly and exclusively tied to year over year appropriations. DHS projections of service capacity are based on current variables and anticipated resource levels but do not have a direct link to the amount of funding or appropriations available in the future. States must forecast how many individuals they can serve and ensure they have the funding and capacity to do so. States are required to be accurate with their projections, per CMS “the number of persons to be served should be based on a careful appraisal of the resources a state has to underwrite the cost of waiver services.” Any significant changes in the number of “slots” for a waiver must be through an amendment to the waiver. An amendment to reduce the maximum number of waiver participants below the number currently served may only be made effective on the date CMS approves the amendment. The amendment request must include information concerning the impact of the reduction on existing waiver participants.

See Tab C: Application for a 1915(c)Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria (CMS, 2015)

DHS Response:

Misrepresentation of Data - The DDS wait list is chronological with a current wait of up to 13 years, resulting in children not having the opportunity to be served during the majority of their childhood. Exceptions are made for emergencies such as when children enter state custody. The number of waiver slots is the maximum number to be served by the waiver without amending the waiver, not the budget for services.

Finding 2: The Ratio of Budgeted Community-Based and In-Home Service Waiver Slots to Members Served is Declining, Despite Increases in State and Federal Funding

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DHS Response:

Factually Inaccurate - DHS has six major program areas: Child Welfare Services, Child Support Services, Child Care Services, Developmental Disabilities Services, Community Living and Adult Protective Services and Adult and Family Services.

It is unclear the data that LOFT utilized to support the assertion that DDS has become a diminishing priority since FY13, however it is apparent that there is confusion about the functions of funding for DHS. DHS is around 70% federally funded, but there isn’t a giant pot that this money goes into that allows agency discretion for dispersion - most of our funds are for a very specific purpose. It doesn’t make sense to compare DHS total budget to determine priority. For example, the Adult & Family Services division total budget increased by nearly \$700M, but the appropriated dollars have decreased. This isn’t an indicator of priority of the agency, it is evidence of the increase to 100% federally funded SNAP benefits. DDS appripres less than 10% of the budget but has more than 20% of the appropriated funds (and this doesn’t take into account the changing FMAP rate, which is almost 8% higher now than it was then).

Going deeper into the data, you can see that even though there is only a small increase in the FY21 DDS budget compared to FY16, the composition of the increase is of interest. Assistance has increased more than \$6M over this time period. This is an illustration of compliance with the limits bills - to keep steady the level of service given to waivers. A steady level of service doesn’t mean a steady level of expenditure. Increasing direct service rates mandated in FY19 and FY20, increasing costs of care for waiver recipients (waiver services change throughout the person’s life and generally there is more care required with age), and the granting of emergency services all contribute to increase in expenditure for the same number of people served. As LOFT states, the state cannot grant a waiver without committing to the continuation of the waiver.

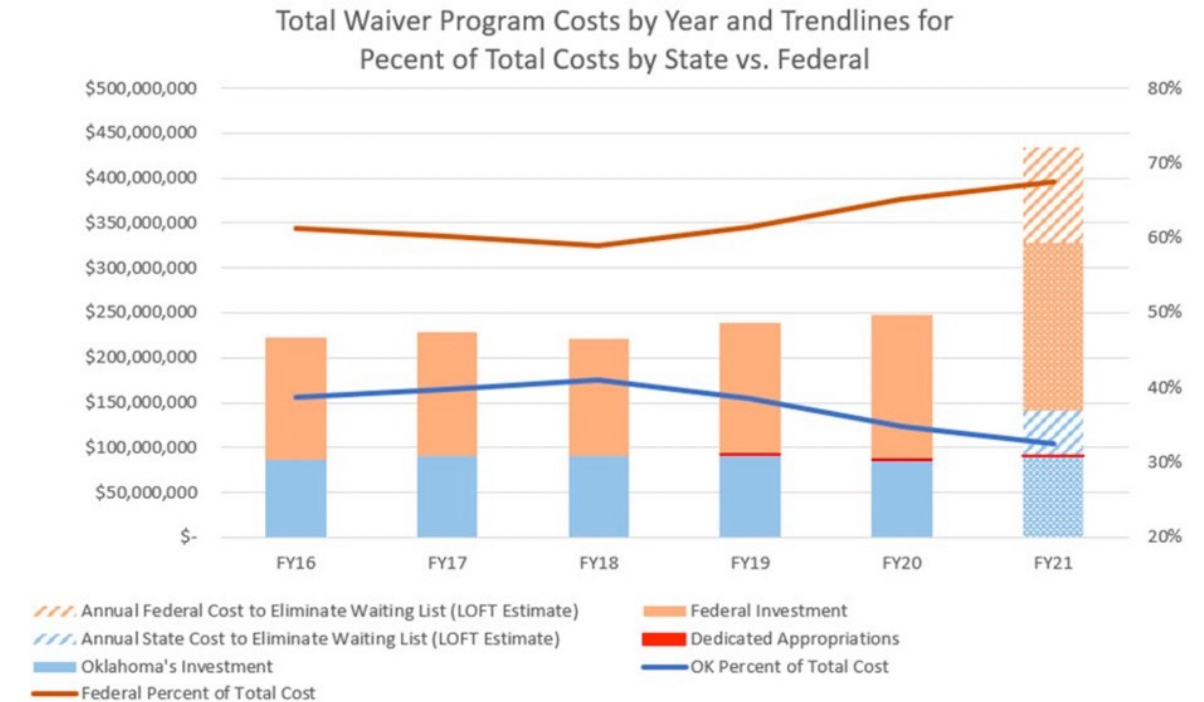
See Tab D: DHS Programs Chart
See Tab E : Accurate DD Expenditure Data and Comparison

DHS Response:
Please see analysis provided on next slide.

through the Community and In-Home Services Waiver Program.

This chart shows the Federal and State investment into the DDS Waiver Program for Community and In-Home Services from FY16 to FY21. This depicts a growing federal investment from FY18 to FY21,

requiring less state investment to maximize program outcomes. Currently, Oklahoma receives an approximate 3:1 Federal match. The bar for FY21 shows LOFT's calculation for the



Source: Legislative Office of Fiscal Transparency

DHS Response:

Factually Inaccurate – LOFT does not understand the way FMAP and Medicaid is funded as is confirmed by the calculations that led to this chart. In the category they cite as average annual cost per person is state dollars, but LOFT then compares those costs against caps that are state and federal dollars as a total. The lack of understanding of Medicaid finance and competency in financial forecasting makes this estimate erroneous at best. Also, LOFT continues to ignore the fact that serving children on an in-home waiver changes as they turn 18 and automatically transition to the in-home waiver for adults. LOFT totally omitted the adult in-home waiver from this slide that compares all waivers and is seemingly the data used to project cost for an entire WL elimination. LOFT never sought any information or understanding from DHS CFO Cathy Menefee.

The average FY21 costs* for:

Homeward Bound Waiver - \$139,091

Community Waiver - \$75,964

In-Home Supports Waiver for Children - \$7,206

In-Home Supports Waiver for Adults - \$17,594

*These numbers are actual services authorized, and utilization runs at approximately 90%.

Appendix G. Table of Waivers Offered by Oklahoma

Table 11: Table of Waivers Offered by Oklahoma

Waiver Name	Agency	Population Served	Began	Persons Served	Average Annual Cost Per Person	Per person cap
Medically Fragile	OHCA	<ul style="list-style-type: none">Medicaid eligibleInstitutional level of careChronic physical condition requiring dependency on medical technology	2010	96	\$63,394	none
ADvantage	DHS	<ul style="list-style-type: none">Frail, elderlyAdults 21 and older with physical disabilities	1993	21,256	\$8,133	\$62,631
Homeward Bound	DHS	<ul style="list-style-type: none">Adults of the Homeward Bound Plaintiff Class	1987	526	\$55,536	none
Community	DHS	<ul style="list-style-type: none">Adults and children with an intellectual disabilityCritical needs that cannot be met with in-home supportInstitutional level of care	1985	2,999	\$29,429	none
In-Home Supports - children	DHS	<ul style="list-style-type: none">Children ages 3-17 with an intellectual disabilityReside in home of a family/friend or a Child Welfare Services homeHave needs that can be met through non-paid and Medicaid resources	1999	113	\$2,928	\$15,426

interagency agreement, the Department of Human Services has authority to direct operations or make programmatic changes to the Waiver Program.

Oklahoma is just one of six states that have a state agency other than the state's Medicaid agency operating the waiver program.

Finding 3: There Are Both Immediate and Long-Term Opportunities to Increase the Number of People Served by Community and Home-Based Services Waivers

LOFT took three approaches to determining what resources would be required to serve all those currently on the Waiting List:

Scenario 1: \$49 million in State funds. This scenario assumes no changes to the program or Waiting List, and that all those waiting are eligible for services.

Scenario 2: No additional investment, but strategically maximize current funds. With this scenario, LOFT estimated the impact of amending the number of waiver slots allocated to different programs. DDS plans to add 50 wavier slots to the Community Waiver in FY23. LOFT found this waiver is not currently serving all member slots budgeted to it. By maintaining the current Community Waiver capacity and reallocating the associated budgeted costs to the In-Home, Child waiver, Oklahoma could serve 476 additional children by FY23, at no additional cost.

Scenario 3: \$5 million strategic investment into just the waiver serving children ages 3-17. If the State were to shift from a “first on, first off” processing of all waivers and instead chronologically serve those within respective waiver groups, it could target funds to a specific waiver for strategic impact. LOFT estimates that with a \$5 million investment into the

DHS Response:

This calculation is not based on data or experience and does not appear to take into account that 97% of people moved from the waiting list onto services go onto a financially capped waiver or that the current experience is that 50% of people do not end up receiving services. We believe that as we begin working more recent applications the closure rate will decrease.

Data about why cases are closed are in this report, despite LOFT stating DHS doesn't have the data.

DHS Response:

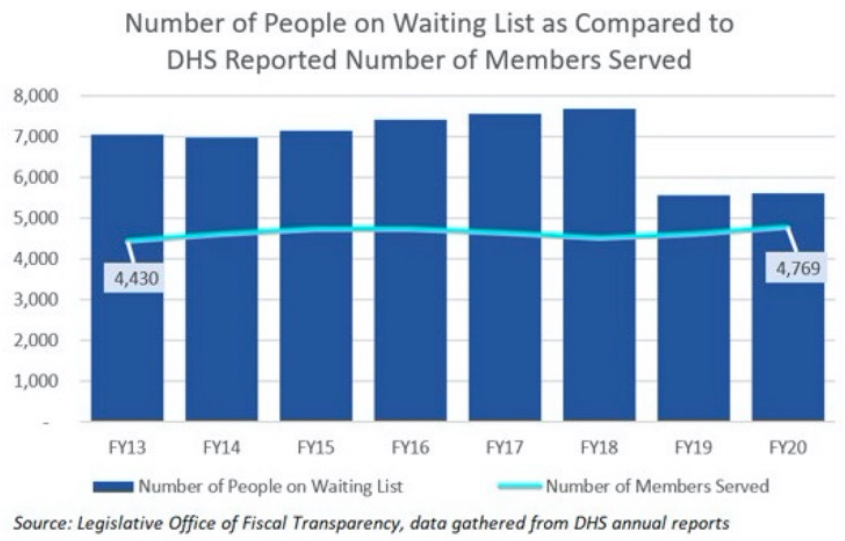
The methodology is flawed and based on incorrect projections for years one through five. Furthermore, the report proposes reducing 50 people served on the Community waiver to fund 476 IHSW children. While this may prove to be an equivalent use of funding and slots, it is only fiscally neutral for year one. As children become 18 years of age, the capitated costs for each persons served increases by \$7,705 per child per year, eventually creating an annual increase in cost of \$3.7 million. Over the course of 50 adult years, this would obligate DHS by a total of \$185 million. This LOFT proposal directly contradicts LOFT's statement of “...the State cannot agree to provide a waiver unless it can also ensure continuation of the waiver, providing stability for the people in need of services.” DHS believes this strategy would be fiscally irresponsible to pursue.

Additionally, children with developmental and intellectual disabilities receive robust services and supports through EPSDT (Early Periodic Screening Diagnosis and Testing), SoonerStart, Department of Rehabilitative Services, and Department of Education through the ages of 18-21.

Has Not Led to Substantial Progress Toward the State’s Goal of Providing Services to All Those Waiting

When state resources and funding are not available to meet the needs of all those who seek services provided through Medicaid waivers, a “waiting list” is created. There are two key drivers to waiting lists: high demand, and program limitations. There are 5,619 physically or mentally disabled Oklahomans waiting to receive services through a state waiver as of March 2021.⁴

Chart 01: Number of People Waiting for Waiver Services and Number of Members being Served. This chart displays the number of persons waiting annually as of July each State Fiscal Year for the past eight fiscal years. The drop in number from 2018 to 2019 is due to list cleanup and not reflective of Community or In-Home Services waivers provided.



DHS Response:
Factually Inaccurate – LOFT’s chart illustrates the number of people receiving services not approaching or exceeding 5,000 people from FY13 through FY20, citing DHS annual reports. The numbers below were taken directly from the DHS FY19 and FY20 annual reports.

Tab F: DHS Annual Reports
FY19 - OKDHS Annual Report: Page 80

“Persons Receiving HCBS Waiver Services”
2015 = 5,610
2016 = 5,560
2017 = 5,390
2018 = 5,239
2019 = 5,242

FY20 Annual Report - 5,306 individuals with intellectual and developmental disabilities received HCBS through Medicaid waiver programs.

See Tab F: FY19 - OKDHS Annual Report: Page 80

DHS Response:

The LOFT statement is misleading by omitting data related to changes in the total number of persons on the wait list.

In FY19:

The LOFT report ignores the fact 465 individuals were added to the wait list through new applications.

There were 53 people added to services in emergency placements at an annual cost of \$2.7 million.

DHS transitioned 166 people from the wait list to services.

Although DHS provided this data to LOFT, the information was omitted in favor of a limited picture skewing the conclusion.

Recent Actions

In an effort to reduce the number of people waiting to receive services, for the past three years the Legislature has dedicated approximately \$2 million annually in additional funds for

⁴ [Key State Policy Choices About Medicaid Home and Community-Based Services \(kff.org\)](https://www.kff.org/medicaid/state-policy-choices-about-medicaid-home-and-community-based-services/)

⁵ DHS responses to LOFT questions

⁶ Ibid.

LOFT Priority Evaluation: DHS Waiver Waiting List

LOC DRAFT

4

“additional services and programs” to those on the Waiting List. ⁷ Between FY19 and FY21, \$5.92 million in additional appropriations was provided to the DHS to serve persons on the Waiting List. LOFT observed that during FY19-FY20 the Waiting List **increased** by 50 people, and the number of members served by these waivers increased by 171. ⁸

As shown in the sidebar, the Legislature has taken action to increase the

The Oklahoma Legislature has dedicated almost \$9 million over the

DHS Response:

Demonstrates a Lack of Understanding - The contract between DHS and Liberty Healthcare defines the scope of work to be performed by the vendor. It is not appropriate to include subsequent work performed by DHS after performance by vendor. The use of data and the implementation of a strategy is the responsibility of DHS which can be completed only after Liberty Healthcare completes the tasks in the scope of work.

TO BE NOTED: Multiple times DHS explained how this data was going to be used, starting at the entrance conference.

As reflected in Figure 01 on the prior page, five assessments of the Waiting List have been conducted in the previous ten years to gather information about the demographics and needs of those waiting, as well as examining other states' best practices. A sixth assessment was initiated in 2021 when DHS executed a contract with Liberty Healthcare of Oklahoma (Liberty). Initial data from this assessment is expected in January of 2022.

LOFT's analysis of Liberty's contract with DHS found that the current assessment is not materially different than prior assessments of the programs. In examining the current contract's statement of work, one key difference from prior assessments is that Liberty will convert the information from the assessment into a dashboard containing demographic information of those on the Waiting List. **However, the contract does not stipulate how the information will be used to provide better service to those on the Waiting List nor does the contract stipulate how information will be used to move those waiting into Waivers.** As of the date of this report, LOFT has not been provided with any

Serve as Single Point of Contact for HCBS Waivers and Services	Case Management Functions	2011 2013 2015 2017 (DHS)
Wait List Management Strategies		
Tailor Assessment Information to Individual Needs		
Services Outside of HCBS Waivers		
Application Process for Services		
Follow For Support		
Outreach and Support to Families		
Connect Resources	Database Management	2011 2013 2015 2017 (OU)
Eligibility Requirements for Waitlist		
Weekly Analysis		
Ad Hoc Reporting		
Reporting Requirements		
Quality Assurance		

Source: Legislative Office of Fiscal Transparency

contract stipulate how information will be used to move those waiting into Waivers. As of the date of this report, LOFT has not been provided with any

Requirements		2017 (OU)
Quality Assurance		

Source: Legislative Office of Fiscal Transparency

¹¹ Estimate provided by OHCA

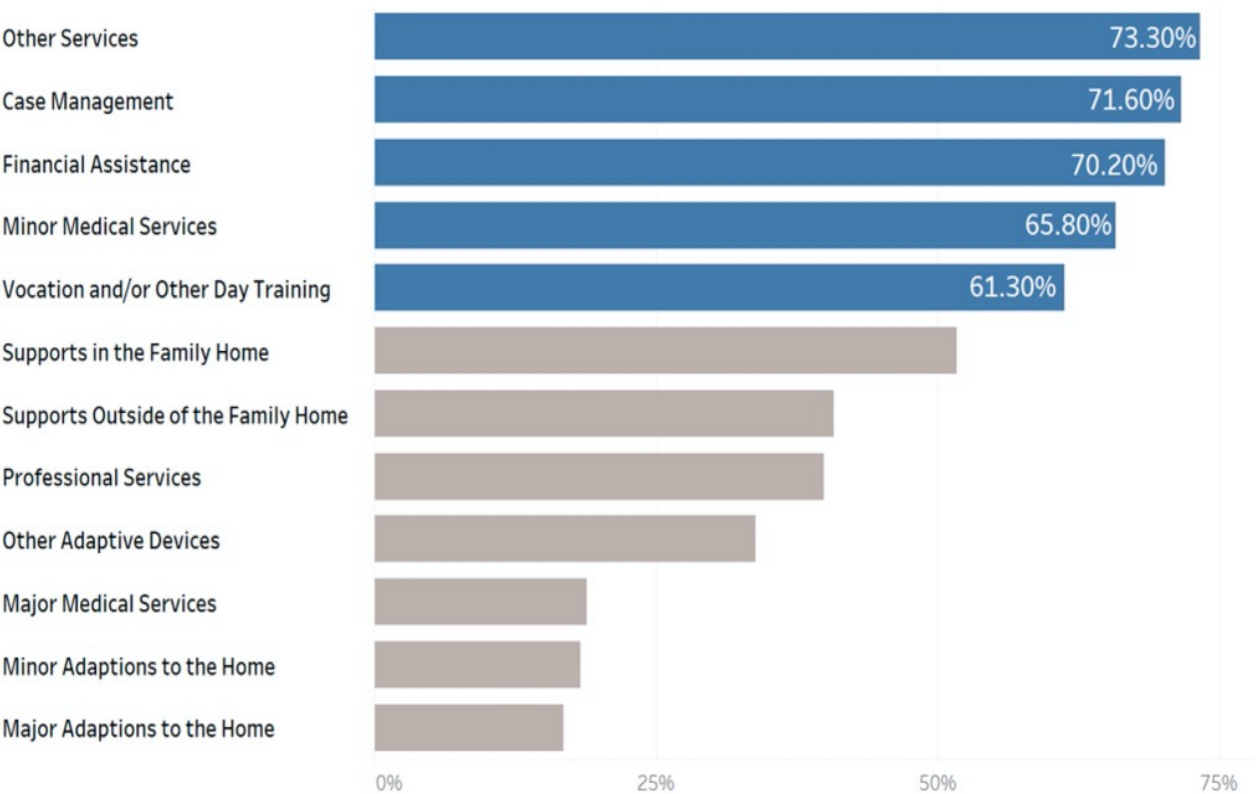
strategic plan from DHS explaining how the Liberty assessment and partnership will achieve the stated goal of eliminating the Waiting List.

Table 02, above, summarizes the statement of work of the Liberty contract compared to the deliverables of prior assessments. This table illustrates what services DHS is requiring Liberty provide during the duration of the contract. Many of these functions, primarily case management, are core duties of staff positions within DHS.¹² Prior assessments were united in recommending that DHS conduct better case management. According to DHS, there are currently 262 case managers within its Developmental Disabilities Services (DDS) division. Through the Liberty contract, the agency is outsourcing this function.¹³

DHS Response:

Factually Inaccurate - During LOFT’s initial interview with DDS, Samantha Galloway, DHS Chief of Staff, described how these assessments will work towards ending the wait list with the financial support of the legislature. These assessments will assign a projected budget to each person on the wait list, creating a data set never before developed. Previous cost estimates were based on speculation and anecdotal evidence rather than a nationally validated assessment tool. Similar cost projections were made in Arkansas with the same tool DHS is using, and the InterRai is currently making the same projections for New York.

Chart 02: Services Most Requested Services by Age Group for those on the Waiting List.



Source: Legislative Office of Fiscal Transparency’s recreation of Analyze This! 2013 data

DHS Response:
Data is Outdated – The data used is from a 2011 study and a limited follow up study in 2013 by Analyze This. DHS will have current information through the assessment process with Liberty on all members of the waiting list who participate, not just a random sample.

Finding 2: The Ratio of Budgeted Community-Based and In-Home Services Waiver Slots to Members Served is Declining, Despite Increases in State and Federal Funding

Federal statute defines waivers as a predetermined number of slots that can be served at a single point in time during a fiscal year. The agency administering waivers must demonstrate in their federal application continued, annual funding capabilities for the duration of the waiver program. Waiver programs are initially approved on a three-year basis and renewed on a five-year basis.¹⁷ Oklahoma's DDS Waivers are budgeted five years at a time.

DHS's most recent five-year plan was approved in September 2020 and provides forecasted use of each type of waiver through FY25. Notably, the number of In-Home, Child Waivers remains unchanged at a maximum of 250 waivers.

Table 03: This table shows the number of waivers budgeted for, OHCA reported number of members served, DHS number of members served, and the percent of budgeted waivers utilized for OHCA and DHS for fiscal years 2016 through 2020. The Table shows the discrepancies in the numbers reported by the different agencies.¹⁸

	FY16	FY17	FY18	FY19	FY20
Number of Waivers Budgeted For	5,020	5,160	5,275	5,360	5,550
OHCA Reported Members Served	4,989	4,823	4,713	4,722	4,870
DHS Reported Members Served	4,728	4,616	4,513	4,598	4,769

DHS Response:

Misleading – This is an erroneous attempt to illustrate that Oklahoma agencies are inept. The reality is that both agencies pull data from separate systems and for different purposes.

DHS Response:

Demonstrates a Lack of Understanding - Children receive services through IHSW and when they turn 18 transition to the Adult IHSW. This has the effect of a decrease on this waiver, but it is an increase on another waiver. We work the Waiting List in chronological order so we do not “replace” children on the children’s IHSW; some states do not even serve children in HCBS as their needs are met through the state plan and through education.

Figure 04: Community, In-home Adult, and In-Home Child Waivers over the previous five fiscal years.

This figure and the table above demonstrate the difference between the number of waivers budgeted and the number of members served across all three types of waivers being examined. The relative percent utilization of all waivers has decreased since FY16. In the case of In-Home, Child waivers the absolute number of members served has declined while the number of budgeted waiver slots has stayed level. 33.6 percent of the waiting list, or 1,890 people, are ages 3-17 and eligible for In-Home, Child waivers, which has the lowest utilization rate among the HCBS waivers.

Number of Members Served Compared to Waivers Budgeted for FY16 - FY20

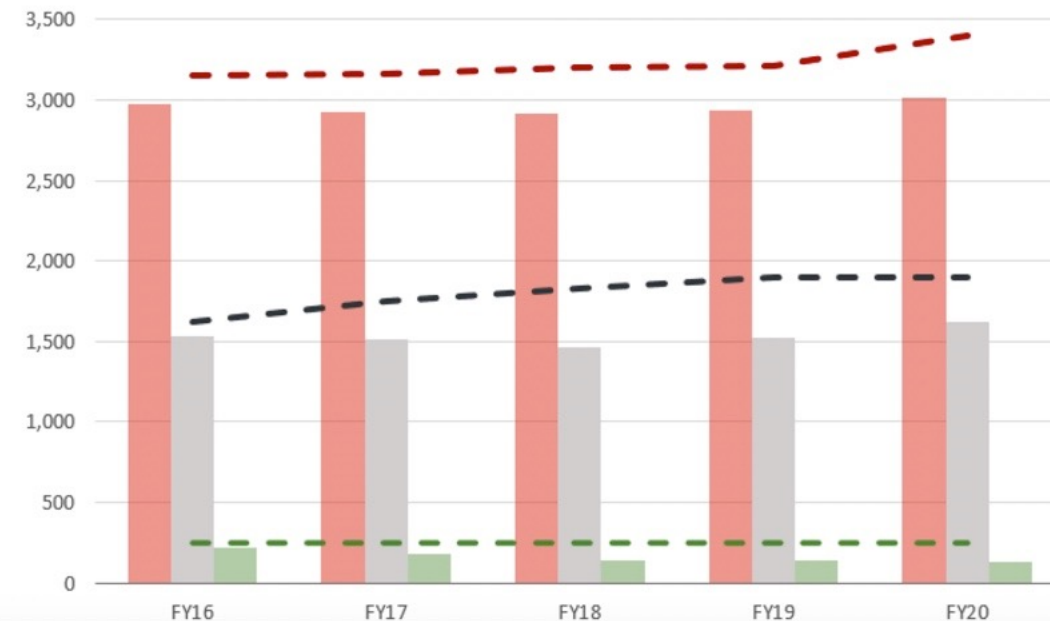
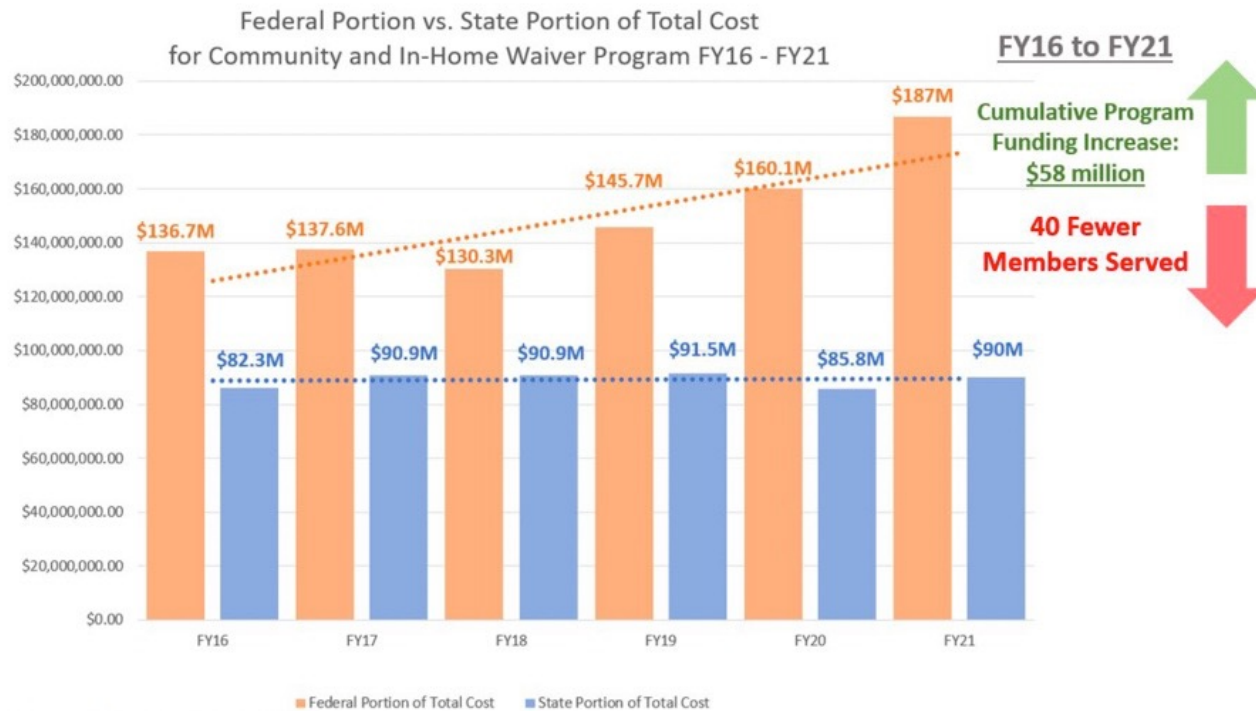


Chart 04: This chart shows the respective state and federal burden of cost trend for the Community-Based and In-Home Support Services waiver program from FY16 to FY21. Federal Medical Assistance Percentage (FMAP) fluctuates yearly based on a state's average income compared to the national average income. As shown in this chart, the FMAP for Oklahoma has generally increased over the previous five fiscal years, lessening the proportion of Oklahoma's investment into Medicaid services. This chart specifically shows the cost sharing for DHS' Community and In-Home Services waiver program.



Source: Legislative Office of Fiscal Transparency, data and blended FMAP provided by OHCA

DHS Response:

Factually Inaccurate - It is unclear where this data originates, it doesn't match any data we have. Of note though, the FMAP fluctuations are inaccurate. FMAP declined FY16 through FY18 before increasing FY19 through FY21. Additionally, there is an impact on services due to the pandemic so it would be disingenuous to compare expenditures for FY20 and FY21.

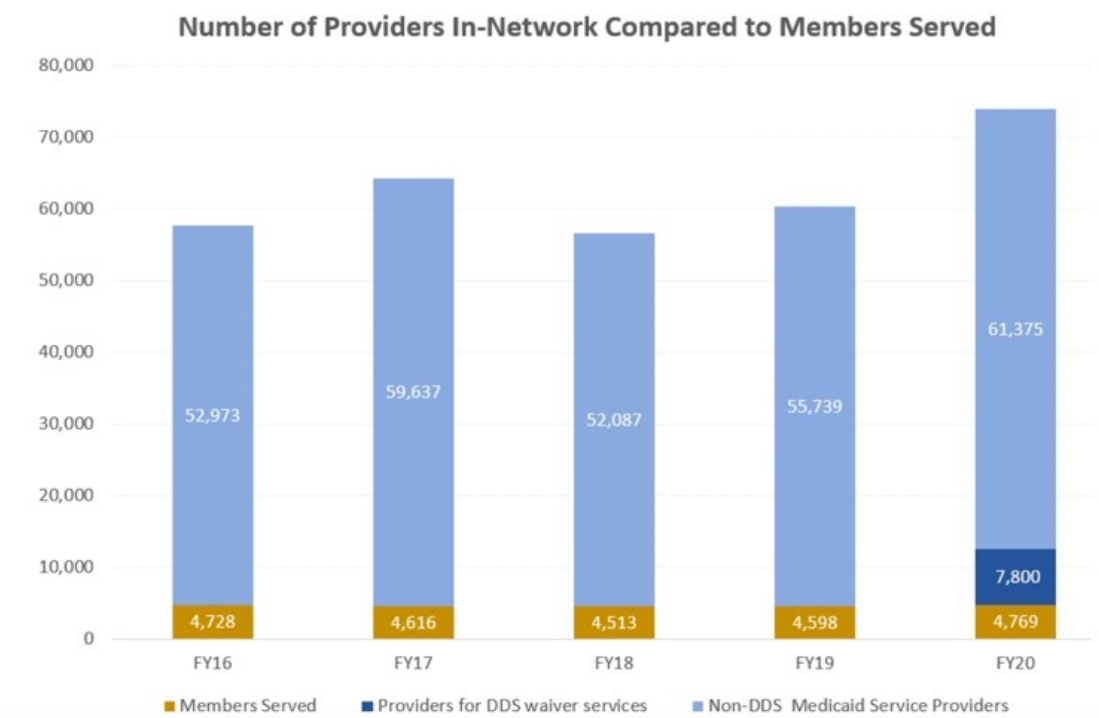
See Tab G: Accurate Blended Oklahoma Historical FMAP

DHS Response:

Factually Inaccurate & Lack of Understanding – The cited 7,800 providers for DDS services is incorrect. This likely represents the number of total contracts among the vendors. DHS has 1,743 distinct vendors, the majority of which are pharmacies and durable medical equipment providers such as Walmart, CVS, Walgreen’s, etc. Within this group there are limited numbers of vendors providing direct services. The most used Waiver services are provided by residential and employment providers across the state, for which there are 112.



Chart 05: Total number of Medicaid Providers within Oklahoma. This chart shows total Medicaid Providers over the previous five fiscal years compared to the number of Members Served within the same period. Data regarding the number of providers for DDS waiver services was not available for FY16 to FY19. The figure for the number of providers for DDS waiver services for FY20 was provided by OHCA. OHCA reported over 69,000 service providers, of which 7,800 were dedicated to providing DDS waiver services in FY20, leaving 61,375 non-DDS waiver service providers remaining.



Source: Legislative Office of Fiscal Transparency, data provided by OHCA



DHS Response:

Lack of Understanding – The table demonstrates a lack of understanding on how funding flows, including that DHS holds the state share for these services. DHS developed a plan using dedicated state dollars to fund the retroactive rate increases to support providers with COVID costs. The intent was to provide immediate relief while not making a long-term funding commitment that could in any way obligate the agency and the legislature long term. The DDS service delivery system is a fee for service model.



According to DHS, a provider rate study is in progress with the intent to establish more providers for the DDS Waiver Program. OHCA, which shares a provider network with DHS, will determine the rates. Table 05, below, displays the various mechanisms available to the State to stabilize and increase provider rates.

Table 05: There are three State entities that can stabilize or increase provider rates; mechanisms include a fund created by the Legislature, efficiency incentive payments administered by DHS, and COVID-related rate stabilization payments from OHCA.

State Entity	Impact on Provider Rates
Legislature	Reimbursement Rate Stabilization Fund, originally for declines in the FMAP rate and later broadened.
DHS	Some amount of the difference between the budgeted and actual waiver amount is paid to providers to incentivize efficiencies.
OHCA	COVID-related Reimbursement Rate Stabilization: 20% every quarter, retroactively from April 2021 to September 2021.

Source: Legislative Office of Fiscal Transparency

The Legislature created a special fund in 2019 to stabilize provider rates.²³ DHS also utilizes one-time funds to provide incentive payments to providers.²⁴ LOFT found no methodology showing how these payments are determined. OHCA has stated an interest in developing selection and performance-based criteria for all Medicaid vendors.²⁵

Federal pandemic relief funds have been used to keep providers solvent during and throughout the recent health crisis. Additionally, state funds have been used to increase provider rates.

Technology

DDS has stated database management is a key limitation to understanding member needs. Additionally, DDS has expressed current limitations with their operating system. The partnership with Liberty should provide data to DDS to make more informed decisions. DDS is in the process of obtaining additional software to assist in managing the operations of the Waiver Program.²⁷

The current system used by DDS is a DOS-based system and is used across various State agencies. Should DDS obtain a new case management software apart from what is being provided by Liberty, OHCA would likely need to create a patch for the systems to share information or would need to switch to the same software. This process will be an additional cost and may further delay processing of waivers. Additionally, though the current system is antiquated, the capabilities are robust. DDS' current limitations are based more on sufficient expertise to understand the innerworkings of the software and up-front case management to obtain the data needed.

DHS Response:

Lack of Understanding - The Office of Management and Enterprise Services is charged with IT strategy for all state agencies. Our best information is that LOFT did not reach out to understand the current or future state of technology as it related to DDS. Therap is a modern software solution as a data management system. Therap has far greater functionality than the prior system that was an ongoing custom build for approximately the past 25 years. Therap is also more cost efficient.

²⁷ As relayed to LOFT by DHS personnel on July 8th, 2021.

Medicaid and Administrative Rules Regarding In-Take

DHS has stated “Medicaid rules” prevent the agency from conducting an in-take process capturing an individual’s needs upon joining the Waiting List. DHS asserts this action would initiate a “time clock” by identifying a need. LOFT’s evaluation found no evidence of state or federal statutes with time constraints that would prohibit in-take of individuals and assumes DHS is misinterpreting the required window to provide services.

At the Federal level, the DDS Waiver Program is bound by the Social Security Act (SSA), specifically Section 1915 (c). This section of the SSA defines waivers and provides the rules of governing. At the state level, OHCA Administrative Rules govern the DDS Waiver Program. These administrative rules stipulate a “time clock”: §317-40-1-(e) states “...**when resources are sufficient for initiation** of HCBS Waiver services, DDS ensures action regarding a request for services occurs within 45-calendar days.” Based on evaluation of federal and state rules, LOFT finds no limitations as to when case management can be initiated. The requirement to provide services within 45 days is only triggered when both an individual’s need has been identified and resources are available.

DHS Response:

Clarification - There is a historical interpretation in Oklahoma, and many other states, that if a state approached a certain threshold for determining eligibility, there was a Medicaid requirement to serve the person promptly. This Liberty Healthcare contract and new approach to manage how people wait demonstrates DHS taking a bold and different path forward.

As you can see from the NASDDD report in Tab H, this has been a national interpretation for many states for many years. In Oklahoma, people are on a waiting list to be determined eligible and receive services.

See Tab H: Waiting Lists and Medicaid Home and Community-Based Services, National State Directors for Developmental Disabilities

DHS Response:

Inappropriate use of transparency - As was acknowledged by Samantha Galloway at the entrance conference with LOFT, the new DDS leadership team during the last few years identified “erroneous calculations and assumptions” made by their predecessors and proactively worked to correct past practice. As cited by LOFT, this identification led DDS to increase the number of persons contacted to receive services from 400 to 800. DHS believes this accomplishment should be celebrated as more people on the wait list will receive services and the program is better managed.

DHS Response:

Factually Inaccurate - These percentages are inaccurate and intended to sensationalize the death rate of those who are waiting.

See Tab I: Worked Waiting List Chart FY20 and FY21

The Legislature has been clear in its intent for new funds to be used to directly serve those who have been waiting for waiver services. Senate Bill 1932, a 2020 “budget limitation” bill providing details for how the Department of Human Services should expend its annual budget, states the additional \$1.92 million in funding ***“shall be used to provide additional services and programs for persons with developmental disabilities in order to reduce the size of the Developmental Disabilities Services Division Waiting List based on need and shall be used to supplement rather than replace existing resources and programs.”***

In response to LOFT’s inquiry about how the Legislature’s dedicated funds have been used, DHS stated the funds were “applied to the agency’s bottom line.”²⁸ DDS further acknowledged “erroneous calculation and assumptions” had been used to determine how many people have been moved off the Waiting List.²⁹ According to DDS, in previous years, the agency identified 400 people to be contacted to determine if services were still needed. Based on new assumptions and calculations, DDS believes it could identify 800 people in 2021 to potentially move into services.

According to the data provided by DDS, 421 individuals were contacted through August of 2021. Of those contacted, approximately 52 percent were not placed into Community or In-Home Services.³⁰ The five most common reasons for not placing a person into waiver services were:

- No response received (20.54 percent)
- Declined services (19.2 percent)
- Non-cooperation (14.73 percent)
- Unable to locate (14.73 percent)
- Chose to remain on the Waiting List (12.5 percent).

Of note, approximately five percent of those contacted were not placed into the DDS Program because they were deceased prior to being offered a waiver.

“...five percent of those contacted were not placed into the DDS Program because they were deceased prior to being offered a waiver.”

DHS Response:

Lack of Understanding - Functionally, DHS administers the program and OHCA pays the claims. The chart is included in every waiver application and is not considered atypical as most states have the majority of boxes checked for the operating agency as well as the Medicaid agency if they are not the same.

OHCA has delegated its authority to direct operations or make programmatic changes to DHS through an interagency agreement. This document provides guidance for how the two agencies will cooperate in developing the waiver plans’ operations, rules, and how they will address problems.

Figure 06: Functions by Agency related to oversight of Community and In-Home Based Waivers.
The figure reflects duplication of administrative functions between the Oklahoma Health Care Authority (OHCA) as the Medicaid Agency, and the Oklahoma Department of Human Services (DHS) as the Operating Agency for the Community.

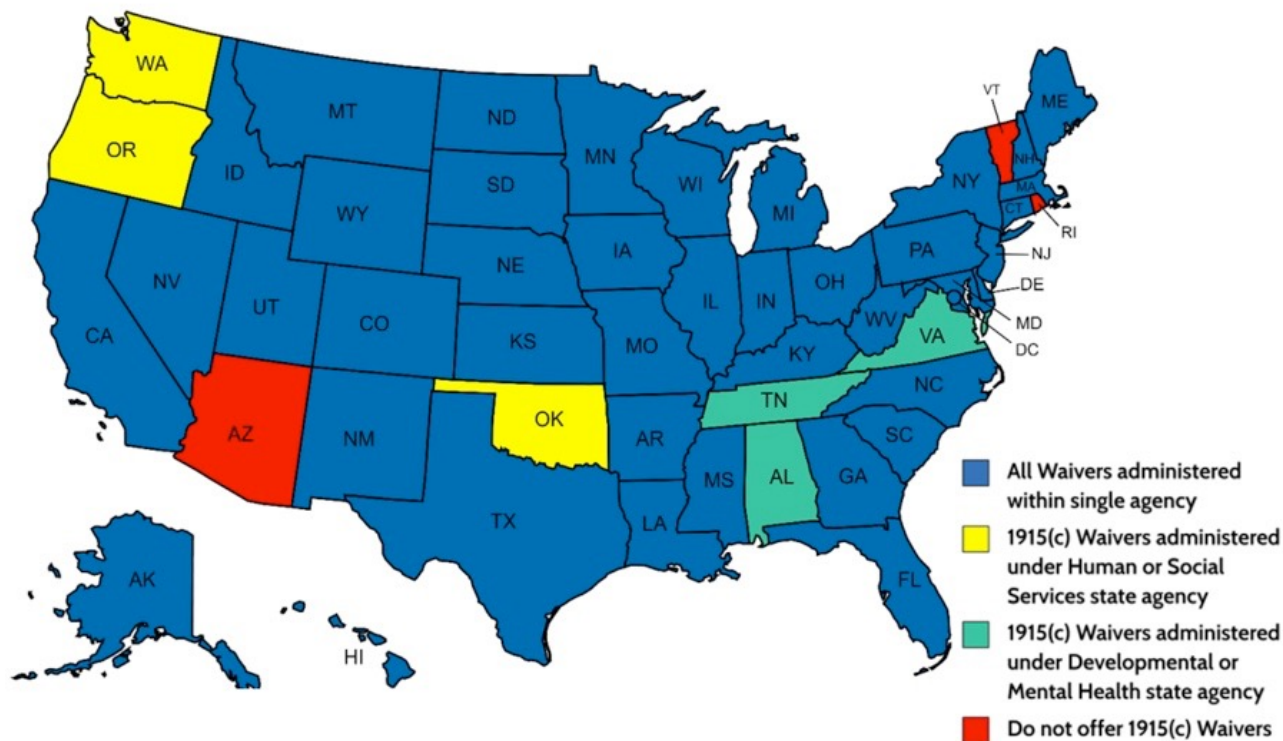
Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed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

Source: OHCA’s Medicaid Waiver Application Filed with CMS

Figure 06, above, demonstrates the roles of each agency as provided in the CMS waiver application. Based on the Liberty contract, many of the functions listed under the operating

state's comparable 1915 (c) program application to CMS. Each application lists the designated "oversight" entity and the "operating" entity. Further research was conducted by LOFT to understand each state's structure and determine if the "oversight" entity and "operating" entity were the same agency or divisions within one agency.³⁹

Map of United States Showing Different Structures for 1915(c) Waivers in State Agencies



Source: Legislative Office of Fiscal Transparency

DHS Response:

Factually Inaccurate – p.5 of Medicaid Forward reads *“Partnership with sister state agencies. In FY2016, services for individuals with intellectual and developmental disabilities (ID/DD) were operated or co-operated by agencies other than the single state Medicaid agency in 30 states.....”*

See Tab J: Medicaid Forward

Table 07: This table contains information on Oklahoma, Missouri, and Ohio's Waiting Lists, including best practices identified by LOFT through direct outreach and research. DHS identified Missouri as a state its views as an industry leader, and Missouri identified Ohio as a best-practice state.

State	HCBS Waiver Total Cost	Average People Served	Weighted Cost Per Waiver	Waiting List	Understand Needs of People on Waiting List	Most Recent Fiscal Year Available	2020 FMAP Rate
Ohio	\$1,723,038,768	40,728	\$42,306	68,644	Yes	FY 20	\$2.37
<p>•Ohio statutorily defines and provides the process of how people are placed on the Medicaid waiver waiting list through Rule 5123-9-24. While the process is encompassing, Waiting List requirements are summarized by two factors: 1) have qualifying condition, 2) and are assessed to have unmet needs for HCBS within the next 12 months.</p> <p>•Require county board of developmental disabilities to conduct needs assessment with information flowing up to Ohio Department of Medicaid. County Boards are additionally tasked with determining the level of need within their district for each type of waiver for upcoming budget year.</p> <p>•OUTCOMES : Ohio is a decentralized process which funnels information from the bottom up to formulate budgetary needs. The refined process, enacted in 2018, allows a more local understanding of needs and identification of funds. This is providing better data to not only formulate budgets, but how to structure future waivers to meet population needs.</p>							
Missouri	\$974,486,092	12,974	\$75,111	0	Yes	FY 19	\$2.64
<p>•Missouri offers case management at the onset of the process. At times, case management is outsourced to meet the demand of current persons awaiting Medicaid waiver.</p> <p>•Frontloading case management provides metrics to allow the State to better budget Medicaid waiver needs.</p> <p>•OUTCOMES : No long-term waiting lists. By having transparent data and understanding the full needs people applying to Medicaid Waivers allows Missouri to fully fund all waiver requests each year. While there may be waiting lists which occasionally arise from the need of a particular service, this need is met within a fiscal year.</p>							
Oklahoma	\$331,191,178	5,016	\$50,490	5,711	No	FY 20	\$2.92
<p>•Little is known regarding Oklahoma's Medicaid waiver process and waiting list. A majority of information was provided through outside advocacy groups and the Oklahoma Health Care Authority. Additionally, through the course of this evaluation, LOFT discovered numerous reports and studies, dating as far back as 2011, which indicated Oklahoma could benefit from several of the best practices identified within this table. Furthermore, LOFT observed no evidence of actions taken by OHS to implement the earlier recommendations.</p> <p>OUTCOMES :Oklahoma's Community and In-home Serve Medicaid waiver process have remained mostly unchanged for over a decade.</p>							

Source: Legislative Office of Fiscal Transparency

DHS Response:

Inappropriate - LOFT asserts that the vast majority of information was provided through outside advocacy groups and OHCA and that LOFT knows little about Oklahoma's Waiver process and WL. We agree, despite hundreds of hours invested by the DHS team into building LOFTs understanding of these systems and services, this report in fact supports their acknowledgement of a gross lack of understanding or ability to consume and process information. It is incredibly unfortunate for Oklahoma families.

Table 10: DDS Waiver Program Forecast as Presented to CMS. This table is DDS' estimate for the next five fiscal years, as submitted to CMS for renewal of their waiver program. The table shows the number of Community and In-Home Waivers for both adult and children. The figures are what DDS believes the program's cost to be from FY21 to FY25. Notably, DDS shows a 160 waiver increase for Community Waivers and an increase of 480 In-Home, Adult Waivers. In-Home, Child Waiver remain flat at 250 Waivers. In-Home, Child Waivers comprise approximately 4.41 percent of total waivers offered by DDS. This is contrasted to the 3-17 category of the Waiting List, which is approximately 33.64 percent of the total, unadjusted Waiting List as of March 31, 2021.

Waiver Program Forecasts	FY21	FY22	FY23	FY24	FY25
Community					
Number of Waivers	3,150	3,160	3,200	3,210	3,310
Forecasted Cost per Waiver	\$71,289	\$71,295	\$77,458	\$75,045	\$69,996
Total Cost	\$224,560,602	\$225,291,726	\$247,866,112	\$240,895,991	\$231,686,826
In-Home, Adult					
Number of Waivers	1,620	1,750	1,900	2,100	2,100
Forecasted Cost per Waiver	\$16,373	\$18,293	\$17,738	\$14,446	\$14,447
Total Cost	\$26,524,147	\$32,013,030	\$33,702,865	\$30,335,844	\$30,338,784
In-Home, Child					
Number of Waivers	250	250	250	250	250
Budgeted Cost per Waiver	\$9,867	\$11,072	\$8,126	\$4,967	\$4,967
Total Cost	\$2,466,815	\$2,767,988	\$2,031,445	\$1,241,850	\$1,241,850
Total Program Cost	\$253,551,564	\$260,072,744	\$283,600,422	\$272,473,685	\$263,267,460

Source: Legislative Office of Fiscal Transparency, data obtained from DDS Waiver application to CMS

Table 10, above, shows the budget forecast for the DDS Waiver Program as submitted to CMS. As previously noted within this report, Medicaid requires the submittal of any waiver program renewal to be accompanied with a five-year forecast with the predetermined number of waivers. and the cost to serve those waivers. Of note. year five costs are anticipated by DDS to

DHS Response:

Factually inaccurate - Not all DHS waivers are not on the same renewal cycle. The columns listed as FY21 through FY25 are waiver years one through five for each waiver and do not correspond to current and upcoming fiscal years.

The Community Waiver renewed in July of 2021 and are not projections for the next five waiver years. The IHSW waivers will renew in July 2022 and as of today, projections have not been submitted to CMS for the upcoming fiscal years. Projected costs vary and change through the amendment process and these numbers have changed over the years, including the projected costs.

Projections are modified when data is received from the 372 report (OHCA User Utilization & Costs). These modifications are submitted in conjunction with other amendments with a lag time in reporting of one to one and a half years for the 372 report.

Scenario 3: Strategic Investment of \$5 Million Into In-Home, Child Waivers

DHS has stated the Waiting List “could be fixed with \$5 million.”⁴⁷ While LOFT’s analysis for Scenario 1 shows the required investment would exceed \$49 million, LOFT analyzed the impact \$5 million would have on the 3-17 age group, which represents one-third of those waiting for services. In Scenario 3, which would require a programmatic targeted shift away from “first on, first off” processing of all waivers, demonstrates that a strategic investment of \$5 million into the In-Home, Child Waivers would serve an additional 1,378 children. The actual number of people waiting served may be even higher, as only 55 percent of those on the Wait List accept services, as explained on page 28.

This scenario presents just one example of how additional investments can be paired with program changes to target specific demographics, conditions, or level of need.

Figure 12: By providing \$5 million in new State funding, DHS would have the resources to serve 1,378 children waiting for In-Home, Child Waivers.



DHS Response:
Factually inaccurate - DHS attempted to clarify.
See Tab K: Shannon Rios Email

317:40-1-1. ..

[Revised 09-01-17]

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

- (1) accessing, with Oklahoma Department of Human Services (DHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;
- (2) cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;
- (3) choosing between services provided through an HCBS Waiver or institutional care; and
- (4) reporting any changes in address or other contact information to DHS within 30-calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare eligibility requirements established by law, regulatory authority, and policy within funding available through State or Federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions per OAC 317:35-9-5. The applicant:

(A) must be determined financially eligible for SoonerCare per OAC 317:35-9-68;

(B) may not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section 1-820 of Title 63 of the Oklahoma Statutes (O.S. 63-1-820), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) may not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated

employment services, or assisted living without Waiver supports OAC 340:100-5-22.2; and

(D) must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) meet all criteria listed in (c) of this Section; and

(B) be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(C) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU);

(D) be 3 years of age or older;

(E) be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122; .

(F) reside in:

(i) the home of a family member or friend;

(ii) his or her own home;

(iii) a DHS Child Welfare Services (CWS) foster home; or

(iv) a CWS group home; and

(vii) have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare resources available to the individual and HCBS Waiver resources within the annual per capita Waiver limit agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) meet all criteria listed in (c) of this Section;

(B) be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

(C) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition by DDS and be covered under the State's alternative disposition plan adopted under Section 1919(e) (7) (E) of the Social Security Act; or

(D) be determined to have a disability and a diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or the OHCA LOCEU; and

(E) be 3 years of age or older; and

(F) be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122; and

(G) have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

(A) be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(B) meet all criteria for HCBS Waiver services listed in (c) of this Section; and

(C) be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) meet ICF/IID Institutional Level of Care requirements per OAC 317:30-5-122 as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) a psychological evaluation, by a licensed psychologist that includes:

(i) a full-scale, functional and/or adaptive assessment; and

(ii) a statement of age of onset of the disability; and (iii) intelligence testing that yields a full-scale, intelligence quotient.

(I) Intelligence testing results obtained at 16 years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between 7 to 16 years of age are considered current for four years when the full-scale intelligence quotient is less than 40, and for two years when the intelligence quotient is 40 or above.

(II) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) a social service summary, current within 12 months of the requested approval date that includes a developmental history; and

(C) a medical evaluation, current within 90-calendar days of the requested approval date; and

(D) a completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation per Form 06MP001E, Request for Developmental Disabilities Services for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List when he or she:

(A) is found to be ineligible for services;

(B) cannot be located by DHS;

(C) does not provide DHS-requested information or fails to respond;

(D) is not an Oklahoma resident at the requested Waiver approval date;

or

(E) declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within 45-calendar days. When action is not taken within the required 45-calendar days, the applicant may seek resolution per OAC 340:2-5-61.

(1) Applicants are allowed 60-calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within 60-calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) an emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

(A) the person is unable to care for himself or herself and:

(i) the person's caretaker, per 43A O.S. '10-103:

(I) is hospitalized;

(II) moved into a nursing facility;

(III) is permanently incapacitated; or

(IV) died; and

(ii) there is no caretaker to provide needed care to the individual;
or

(iii) an eligible person is living at a homeless shelter or on the street;

(B) DHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;

(C) the behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, the person is routinely physically assaultive to

the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or

(D) the person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so;

(2) the Legislature appropriated special funds with which to serve a specific group or a specific class of individuals per HCBS Waiver provisions;

(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in DHS custody receiving services from DHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver;

(4) individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e) (7) (E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.

(1) When a member receiving services funded through the IHSW for children becomes 18 years of age, services through the IHSW for adults becomes effective.

(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:

(A) a member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and

(B) funding is available per OAC 317:35-9-5.

(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the

OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care per OAC 317:30-5-122 and confirms a diagnosis of intellectual disability per the Diagnostic and Statistical Manual of Mental Disorders.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf 30-calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) a member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) a member is incarcerated;

(3) a member is financially ineligible to receive Waiver services;

(4) a member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) a member is determined by the OHCA LOCEU to no longer be eligible;

(6) a member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than 30-consecutive calendar days;

(8) the guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process per OAC 340:100-5-50 through 340:100-5-58;

(9) the guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of DHS policy or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;

(10) the member is determined to no longer be SoonerCare eligible;

(11) there is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) the member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to

complete plan development or monitoring activities as required per OAC 340:100-3-27 and the member or the individual acting on the member's behalf:

(A) does not respond to the notice of intent to terminate; or

(B) the response prohibits the case manager from being able to complete plan development or monitoring activities as required per OAC 340:100-3-27;

(13) the member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) it is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;

(15) the member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) a family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official DHS representatives; or

(17) a member no longer receives a minimum of one Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) the situation resulting in case closure of a Hissom class member is resolved;

(2) a member is incarcerated for 90-calendar days or less;

(3) a member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for 90-calendar days or less; or

(4) a member's SoonerCare eligibility is re-established within 90-calendar days of the SoonerCare ineligibility date.

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Assessment	Company	Random Sample	Nationally Accredited	Number of people Assessed	% of Waitlist Assessed	Total Number of Questions
OK DDSD WL Study 2011	Analyze This	Yes	No	809	12.94	30
Follow Up Study 2013	Analyze This	N/A	No	71	1.01	10 to 26
Needs Assessment for Individuals with IDD: A Summary of the Findings 2017	OPOA/DHS	Yes	No	414	5.48	75
OKDHS Priority of Need Analysis and Screening Tool Phase II Summary Report 9/1/2017	OUCPM	Yes	No	214	2.83	116
2021 Waiting List Assessments	Liberty	No	Yes	5000	100	309 to 441

Item B-3-a: Unduplicated Number of Participants

Instructions

In Table B-3-a, enter the maximum number of unduplicated participants who may be served during each waiver year that the waiver is in effect. In the case of a new waiver (including a new waiver to replace an approved waiver), enter figures for waiver years 1-3, or years 1 – 5 if applicable. For a waiver renewal, enter figures for waiver years 1-5. The numbers entered in this table are also entered into Table J-2-a in Appendix J (Cost-Neutrality Demonstration). The web-based application automatically displays the correct number of rows based on whether the state is submitting a new or renewal waiver. In addition, the web-based application links this table to Table J-2-a.

Technical Guidance

The number specified for each waiver year constitutes the maximum limit on the unduplicated number of participants that the waiver will serve (also known as Factor C). It is up to the state to specify this maximum. Until the maximum number of unduplicated participants in the approved waiver is reached, a state may not deny entry to the waiver of otherwise eligible individuals unless the state elects to establish a point-in-time enrollment limit, adopts a phase-in or phase-out schedule, or reserves capacity for specified purposes (see following items). As a consequence, the number of persons who will be served should be based on a careful appraisal of the resources that the state has available to underwrite the costs of waiver services.

Post-approval, the maximum number of unduplicated participants may be modified by submitting a waiver amendment to CMS to increase or decrease the maximum. An amendment to increase the maximum may be made effective to the beginning of the current waiver year. When more individuals are served in the waiver than the maximum, submit an amendment to align the waiver with the number of individuals served. An amendment to reduce the maximum number of waiver participants below the number currently being served may only be made effective on the date that CMS approves the amendment. Consequently, when a reduction is necessary, an amendment should be submitted as soon as the need for a change to the participant limit is identified. When a reduction in the maximum number of participants is requested, the amendment request must include information concerning the impact of the reduction on existing waiver participants (see *Waiver Application, Submission Requirements, Processes, and Procedures – Other Changes to Approved Waivers* for additional information).

A state may find it necessary to reduce the maximum number of participants because legislative appropriations are insufficient to support the number of persons specified in the approved waiver. In order to effect such a reduction, a state must submit a waiver amendment and the amendment must be formally approved by CMS. As previously noted, in the past, states have been permitted to tie the number of participants to legislative appropriations and notify CMS in writing of the reduction in the number of participants due to legislative appropriations without submitting an amendment. This alternative is no longer available. The waiver is considered to be in effect as approved unless CMS has formally approved an amendment submitted by the state. If a state finds it necessary to freeze waiver enrollment or place a moratorium on new entrants to the waiver, the state also must submit an amendment to CMS to revise the unduplicated participant cap for the affected waiver year.

Application for a 1915c Home and Community-Based Waiver, version 3.5 : Instructions, Technical Guide
and Review Criteria



OKLAHOMA Human Services

FY2016 (DHS Budget Data)

Division	State Budget	% of State Budget	Total Budget	% of Total Budget
ADM & DATA	81,878,285	11%	133,752,826	6%
AFS	87,564,826	12%	1,263,457,839	56%
CAP	122,697,325	16%	126,948,587	6%
CCS	363,192	0%	20,731,724	1%
CSS	17,805,992	2%	58,730,228	3%
CWS	267,381,517	35%	461,587,920	20%
DDS	177,453,831	23%	210,663,918	9%
Grand Total	755,144,969	100%	2,275,873,042	100%

FY2021 (DHS Budget Data)

Division	State Budget	% of State Budget	Total Budget	% of Total Budget
ADM & DATA	100,637,595	13%	188,113,950	6%
AFS	85,653,278	11%	1,987,597,200	63%
CAP	112,480,736	15%	114,591,000	4%
CCS	(2,441,056)	0%	25,035,000	1%
CSS	15,123,762	2%	53,809,000	2%
CWS	301,852,562	39%	575,640,808	18%
DDS	159,093,737	21%	212,746,000	7%
Grand Total	772,400,614	100%	3,157,532,958	100%

DDS Budgets (per PeopleSoft)

	FY 16 Budget	FY 21 Budget	Difference
Admin	666,130	598,000	(68,130)
Assistance	158,051,703	164,447,000	6,395,297
Professional Service	16,563,668	15,910,000	(653,668)
Salary	35,008,202	31,132,000	(3,876,202)
Travel	374,215	659,000	284,785
Grand Total	210,663,918	212,746,000	2,082,082

Department of Human Services
Business Unit - 83000
FY 2021 Operating Budget Comparison by Department and Account
as of June 30, 2021

Department: 2200001 Developmentally Disabled Svcs

Account	Annual Budget	YTD Budget	Expenses	Encumbrance	Pre-Encumbrance	Total Exp, Enc, Pre-Enc	Annual Variance	YTD Variance	Annual %	YTD %
511 Salary Expense	20,848,000	20,848,000	19,457,882.78	0.00	0.00	19,457,882.78	1,390,117.22	1,390,117.22	93.33	93.33
512 Insur.Prem.Hlth-Life,etc	5,300,000	5,300,000	5,218,759.07	0.00	0.00	5,218,759.07	81,240.93	81,240.93	98.47	98.47
513 FICA-Retirement Contriburi	4,984,000	4,984,000	4,646,163.48	0.00	0.00	4,646,163.48	337,836.52	337,836.52	93.22	93.22
515 Professional Services	15,910,000	15,910,000	14,865,488.62	15,083,742.23	0.00	29,949,230.85	-14,039,230.85	-14,039,230.85	188.24	188.24
519 Inter/Intra Agy Pmt-Pers S	0	0	24,065.40	0.00	0.00	24,065.40	-24,065.40	-24,065.40	~	~
521 Travel - Reimbursements	632,000	632,000	1,448.14	0.00	0.00	1,448.14	630,551.86	630,551.86	0.23	0.23
522 Travel - Agency Direct Pmt	27,000	27,000	4,055.00	0.00	0.00	4,055.00	22,945.00	22,945.00	15.02	15.02
531 Misc. Administrative Expen	474,000	474,000	226,093.43	472,115.00	0.00	698,208.43	-224,208.43	-224,208.43	147.30	147.30
532 Rent Expense	67,000	67,000	2,375.97	0.00	0.00	2,375.97	64,624.03	64,624.03	3.55	3.55
533 Maintenance & Repair Expen	12,000	12,000	0.00	0.00	0.00	0.00	12,000.00	12,000.00	0.00	0.00
534 Specialized Sup & Mat.Expe	6,000	6,000	0.00	0.00	0.00	0.00	6,000.00	6,000.00	0.00	0.00
535 Production,Safety,Security	1,000	1,000	0.00	0.00	0.00	0.00	1,000.00	1,000.00	0.00	0.00
536 General Operating Expenses	11,000	11,000	437.11	0.00	0.00	437.11	10,562.89	10,562.89	3.97	3.97
541 Office Furniture & Equipme	23,000	23,000	0.99	9,480.00	0.00	9,480.99	13,519.01	13,519.01	41.22	41.22
542 Library Equipment-Resource	4,000	4,000	0.00	0.00	0.00	0.00	4,000.00	4,000.00	0.00	0.00
551 SocSvc-Assist,Grant&Provid	163,872,000	163,872,000	118,130,209.58	0.00	0.00	118,130,209.58	45,741,790.42	45,741,790.42	72.09	72.09
552 Scholar.,Tuition,Incentive	1,000	1,000	0.00	0.00	0.00	0.00	1,000.00	1,000.00	0.00	0.00
553 Refunds,Idemnitites,Restitu	574,000	574,000	82,854.28	0.00	0.00	82,854.28	491,145.72	491,145.72	14.43	14.43
561 Loans,Taxes,Other Disburse	0	0	80.00	0.00	0.00	80.00	-80.00	-80.00	~	~
562 Transfers	0	0	117.20	0.00	0.00	117.20	-117.20	-117.20	~	~
601 AFP Encumbrances	0	0	0.00	105,000.00	0.00	105,000.00	-105,000.00	-105,000.00	~	~
	212,746,000	212,746,000	162,660,031.05	15,670,337.23	0.00	178,330,368.28	34,415,631.72	34,415,631.72	83.82	83.82
Class Funding										
32100 Fy01 Human Ser Disbursing	60,938,000	60,938,000	51,632,185.84	15,670,337.23	0.00	67,302,523.07	-6,364,523.07	-6,364,523.07	110.44	110.44
34000 Human Sev Medical & Assist	151,808,000	151,808,000	111,027,845.21	0.00	0.00	111,027,845.21	40,780,154.79	40,780,154.79	73.14	73.14
	212,746,000	212,746,000	162,660,031.05	15,670,337.23	0.00	178,330,368.28	34,415,631.72	34,415,631.72	83.82	83.82
Totals for Division 22	212,746,000	212,746,000	162,660,031.05	15,670,337.23	0.00	178,330,368.28	34,415,631.72	34,415,631.72	83.82	83.82

Department of Human Services
Business Unit - 83000
FY 2016 Operating Budget Comparison by Department and Account
as of June 30, 2016

Department: 2200001 Development Disabilities Svcs

Account	Annual Budget	YTD Budget	Expenses	Encumbrance	Pre-Encumbrance	Total Exp, Enc, Pre-Enc	Annual Variance	YTD Variance	Annual %	YTD %
511 Salary Expense	19,781,381	19,781,381	22,147,862.99	0.00	0.00	22,147,862.99	-2,366,481.95	-2,366,481.95	111.96	111.96
512 Insur.Prem-Flth-Life,etc	10,333,835	10,333,835	7,656,510.71	0.00	0.00	7,656,510.71	2,677,324.33	2,677,324.33	74.09	74.09
513 FICA-Retirement Contributi	4,892,986	4,892,986	5,181,010.72	0.00	0.00	5,181,010.72	-288,024.76	-288,024.76	105.89	105.89
515 Professional Services	16,563,668	16,563,668	14,014,998.65	715,000.00	0.00	14,729,998.65	1,833,669.51	1,833,669.51	88.93	88.93
519 Inter/Intra Agy Pmt-Pers S	0	0	18,240.60	0.00	0.00	18,240.60	-18,240.60	-18,240.60	~	~
521 Travel - Reimbursements	365,720	365,720	239,639.57	0.00	0.00	239,639.57	126,080.35	126,080.35	65.53	65.53
522 Travel - Agency Direct Pmt	8,495	8,495	5,502.10	0.00	0.00	5,502.10	2,992.94	2,992.94	64.77	64.77
531 Misc. Administrative Expen	469,297	469,297	354,881.90	0.00	0.00	354,881.90	114,415.18	114,415.18	75.62	75.62
532 Rent Expense	34,041	34,041	23,338.47	0.00	0.00	23,338.47	10,702.53	10,702.53	68.56	68.56
533 Maintenance & Repair Expen	128,229	128,229	104,973.83	0.00	0.00	104,973.83	23,255.17	23,255.17	81.86	81.86
534 Specialized Sup & Mat.Expe	4,985	4,985	376.04	0.00	0.00	376.04	4,608.88	4,608.88	7.54	7.54
535 Production,Safety,Security	2,427	2,427	0.00	0.00	0.00	0.00	2,427.00	2,427.00	0.00	0.00
536 General Operating Expenses	351	351	7,713.89	0.00	0.00	7,713.89	-7,362.89	-7,362.89	2197.69	2197.69
537 Shop Expense	5,056	5,056	3,769.00	0.00	0.00	3,769.00	1,286.96	1,286.96	74.55	74.55
541 Office Furniture & Equipme	4,842	4,842	7,472.23	941.42	0.00	8,413.65	-3,571.65	-3,571.65	173.76	173.76
542 Library Equipment-Resource	8,448	8,448	59.95	0.00	0.00	59.95	8,388.05	8,388.05	0.71	0.71
543 Lease Purchases	419	419	0.00	0.00	0.00	0.00	419.04	419.04	0.00	0.00
546 Buildings-Purch., Constr,Re	5,375	5,375	0.00	5,960.00	0.00	5,960.00	-584.96	-584.96	110.88	110.88
551 SocSvc-Assist,Grant&Provid	157,992,919	157,992,919	151,709,335.95	0.00	0.00	151,709,335.95	6,283,583.13	6,283,583.13	96.02	96.02
552 Scholar . Tuition, Incentive	500	500	0.00	0.00	0.00	0.00	500.04	500.04	0.00	0.00
553 Refunds,Idemnitites,Restitu	58,284	58,284	140,321.59	0.00	0.00	140,321.59	-82,037.59	-82,037.59	240.75	240.75
555 Pmts-Local Gov't,Non-Profit	2,480	2,480	0.00	0.00	0.00	0.00	480.00	480.00	0.00	0.00
561 Loans,Taxes,Other Disburse	0	0	310.00	0.00	0.00	310.00	1,870.04	1,870.04	14.22	14.22
562 Transfers	0	0	1,028.67	0.00	0.00	1,028.67	-1,028.67	-1,028.67	~	~
601 AFP Encumbrances	0	0	0.00	300.00	0.00	300.00	-300.00	-300.00	~	~
810 Req Only	0	0	0.00	360,677.80	0.00	360,677.80	-360,677.80	-360,677.80	~	~
	210,663,918	210,663,918	201,617,346.86	1,082,879.22	0.00	202,700,226.08	7,963,692.28	7,963,692.28	96.22	96.22
Class Funding										
32600 FY 06 Human Svcs Disb Fund	63,893,928	63,893,928	59,636,119.72	1,082,879.22	0.00	60,718,998.94	3,174,929.42	3,174,929.42	95.03	95.03
34000 Human Sev Medical & Assist	146,769,990	146,769,990	141,981,227.14	0.00	0.00	141,981,227.14	4,788,762.86	4,788,762.86	96.74	96.74
	210,663,918	210,663,918	201,617,346.86	1,082,879.22	0.00	202,700,226.08	7,963,692.28	7,963,692.28	96.22	96.22
Totals for Division 22	210,663,918	210,663,918	201,617,346.86	1,082,879.22	0.00	202,700,226.08	7,963,692.28	7,963,692.28	96.22	96.22

DDS

Developmental Disabilities Services

DDS-administered programs tailored to meet each individual's needs include:

- Medicaid Home and Community-based waiver services (HCBS)
- Family Support Assistance Payments
- State-funded group homes, employment, assisted living, respite voucher and guardianship services

Number of individuals served

- 8,100 individuals with intellectual and developmental disabilities, ranging in age from infants to over age 80, were served by one or more programs administered by DDS.
- 5,306 individuals with intellectual and developmental disabilities received HCBS through Medicaid waiver programs.
- 64% of adults served by DDS were employed in jobs in their communities – one of the highest percentages in the nation.
- 1,164 individuals with intellectual and developmental disabilities received state-funded residential or employment services including 182 individuals served in state-funded group homes with 31 providers delivering care.
- 1,449 individuals younger than age 18 received Family Support Assistance Payments.

Adapting to Change during COVID-19

The COVID pandemic presented a significant challenge for DDS customers. DDS and provider agencies established real-time, robust communication opportunities to ensure the safety and wellbeing of more than 4,000 individuals jointly served by DDS and its partner agencies.

While emergency preparedness provisions lessened the blow, there was no way to avoid temporarily shutting down work sites for our customers. This led to a more creative approach of using job coaches to help smaller groups of DDS customers and the development of other employment options that will be available in SFY 2021.

Waiver Programs

Medicaid HCBS waiver programs represent the majority of the services administered. HCBS waiver programs receive appropriated state dollars and matching federal dollars. Because HCBS programs are expanded Medicaid services, recipients must be Medicaid (SoonerCare) eligible.

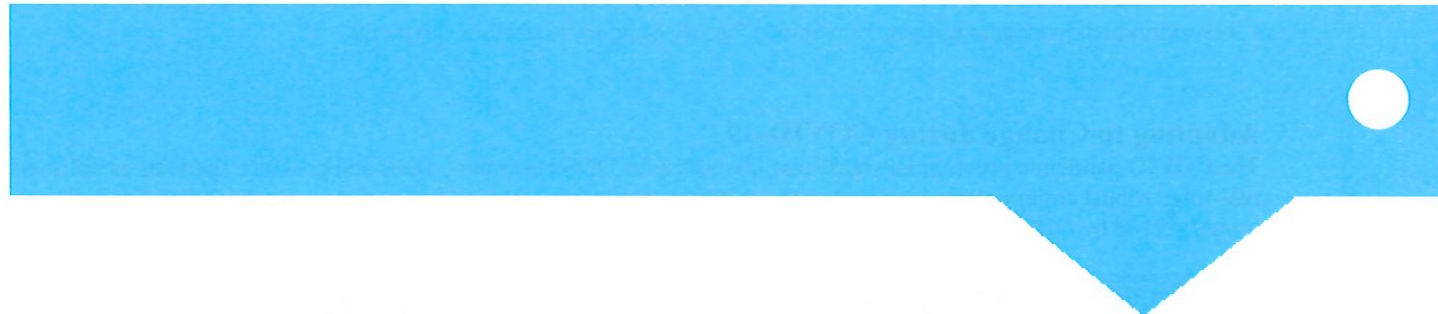
- HCBS waiver programs

- In-Home Supports waiver for adults
- In-Home Supports waiver for children
- Community waiver
- Homeward Bound waiver

Home and Community Based Waiver services

Individuals receiving HCBS live in their own homes, family homes, shared living homes or group homes. Services were provided by 630 different private contract providers including:

- Residential and vocational service agencies
- Nurses
- Dentists
- Occupational therapists
- Physical therapists
- Speech therapists
- Psychologists
- Durable medical equipment suppliers
- Pharmacies
- Architectural modifications
- Assistive technology
- Family training



Number of Individuals Receiving HCBS Waiver Services by State Fiscal Year

- 2016: 5,560
- 2017: 5,390
- 2018: 5,239
- 2019: 5,242
- 2020: 5,222

The average individual cost of serving an adult receiving in-home services ranges from 26 to 32 percent of the annual cost of private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Fifty five percent of individuals receiving HCBS live in a residential setting. They may also receive one or more of the following services:

- Employment services: 64%
- Transportation services: 95%
- Habilitation training services: 66%

Supportive services

In SFY 2020, DDS engaged in newly recognized efforts that afford individuals increased independence with remote supports and supported decision-making.

- Remote supports are the use of technology, such as cell phones and video conferencing, used to support an individual in place of in-person staff supports. Remote supports increased independence, self-advocacy and self-determination. Remote supports will be offered as a waiver service on a broader basis, upon approval by the Centers for Medicare and Medicaid Services.
- Supported decision-making is a pathway for individuals with intellectual disabilities to learn new skills and ideas to improve making their own choices and meeting their own goals. Supported decision-making was part of a research study with Oklahoma State University.

Waiting List

DDS maintains a waiting list for HCBS. During the last three state fiscal years, the state legislature appropriated funding to serve individuals on the list. In SFY 2020, DDS began serving 161 people who had been waiting for services since 2007. Because of foundational work in SFY 2020, DDS is poised to offer a more proactive approach to engage families on the waiting list by assessing for needs and providing resource linkages to meet the needs until waiver services are available. DDS continues to work with stakeholders, advocates, self-advocates and families to serve those on the waiting list.

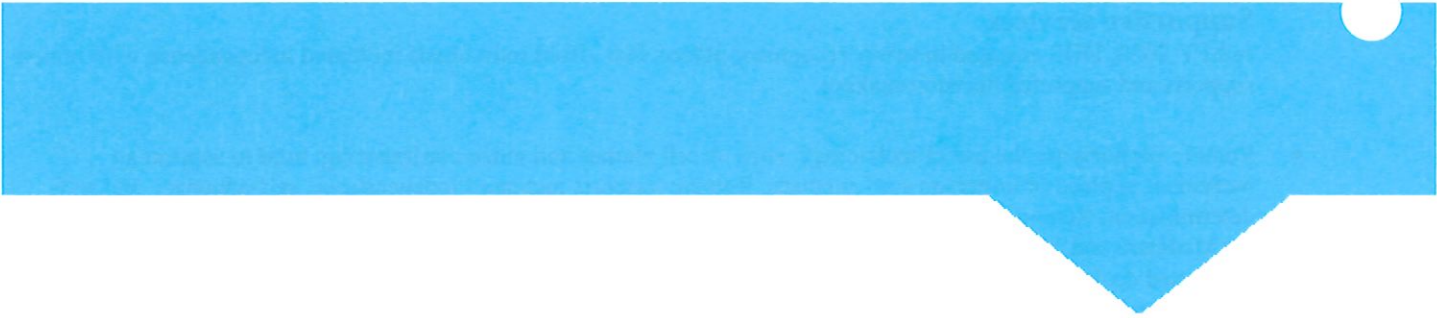
Number of Persons Waiting For Home and Community-Based Services*

2015: 7,137
→ 2016: 7,405
→ 2017: 7,560
→ 2018: 7,673
→ 2019: 5,569
→ 2020: 5,711

**DDS does not verify eligibility for HCBS until funding is available. Individuals on the waiting list are eligible for and often receive services from other programs while they are waiting.*

Demographics of Individuals Waiting for Home and Community-Based Services

- Age range: Infants to over 80 years
- Residents in Oklahoma and Tulsa counties: 2,387
- Younger than age 18: 2,348
- Age 19 to 21: 578
- Age 21 to 55: 2,548
- Reside in their own or family home: 4,486
- On the waiting list for over eight years: 2,600
- Enrolled in Sooner Care: 3,986

- 
- Receive SNAP food benefits: 1,815
 - Receive the Family Support Assistance Payment: 728
 - Participate in state-funded services: 548
 - Receive State Plan Personal Care: 103
 - Receive Adult Day Services through OKDHS Aging Services: 133


State-Funded Services

A number of Oklahomans with intellectual and developmental disabilities are not Medicaid-eligible for various reasons. For these individuals, there are a limited amount of services funded entirely with state dollars. These services include sheltered workshop and community-integrated employment services, group home services and adult day services.

- Individuals received state funded services from 60 providers: 1,164

Family Support Assistance Payments

DDS offers Family Support Assistance Payments to families who are caring for children younger than age 18 with developmental disabilities living at home. The payment is \$250 per month for the first eligible child up to a maximum of \$400 per month, depending on the number of eligible children. These payments are provided to families with annual gross incomes that do not exceed \$45,000 per year and are funded from the federal Temporary Assistance to Needy Families (TANF) grant.

- Children were enrolled for FSAP: 1,449
 - Families represented: 1,364
- 

“I wanted the opportunity to become a man.”

– Justin, DDS service recipient

Justin is one of more than 8,100 individuals with disabilities served by DDS and its community partners. Central State Community Services of Oklahoma (CSCSO) is among many DDS partners providing home and community-based services to individuals with disabilities through supported living services including habilitation training, transportation services and employment.

Justin benefited from DDS supports for several years and was receiving services through CSCSO while living in a residential home in Tulsa County. He had two roommates, but he really wanted to live on his own.

“Justin did not want roommates,” said Dada Mboh, CSCSO Senior Support Coordinator. “We really wanted to help him get his own place and achieve his goal of independence.”

Through the support of his team, Justin was able to move into his own apartment and receive eight hours per day of in-person support services. While receiving that valuable support, Justin decided he wanted to be even less dependent on staff. Justin’s guardian, his brother John, was well aware of Justin’s desire to live on his own with as little assistance as possible. To find the best pathway to make Justin’s dream of independence become reality, John and Justin worked with the provider and case manager to develop a plan and implement it.

“I wanted the opportunity to become a man,” said Justin.

In late March 2020, DDS received approval to use what are called “remote supports” through a temporary emergency approval from the Centers for Medicare and Medicaid Services. Remote supports include the use of cell phones and video conferencing to remotely support an individual instead of providing in-person support by provider staff. Justin quickly chose the option to receive remote supports via phone or online.

“My brother Justin is fiercely independent and sets challenging goals for himself,” said John. “DDS and CSCSO have provided critical support to ensure financial, medical and social stability for Justin which has allowed him to flourish and achieve many life goals in a short period of time.”

In just 18 months, Justin successfully transitioned to his own apartment, completed driver training, received a driver’s license and was hired by a local home improvement center.

“The stability and mentoring from DDS and CSCSO, coupled with Justin’s ambition and positive attitude, have made all his achievements possible,” said John.

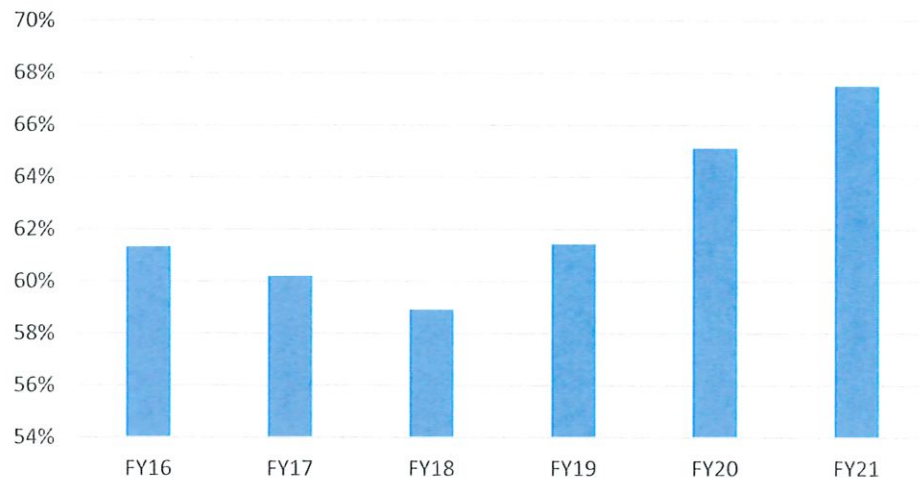
Justin says he feels like he is his “own man” now. He still receives weekly in-person visits from staff, but the visits are dictated by Justin, not by his provider. And if he feels like he needs immediate assistance, his staff at CSCSO are just a phone call or video chat away.

“Justin inspires me,” said Dada. “He is an amazing man.”

Justin continues his impressive pace to become increasingly independent. His next goal is to become his own representative payee, which means he would manage his social security benefits to meet his current and future financial needs.

Justin, John, Dada and DDS. Another example of a mighty team working together to help make a dream come true.

Blended Oklahoma Historical FMAP



and Treatment (EPSDT) requirement for children under 21 cannot have waiting lists.³ As noted in the table below, there are additional, non-1905(a) state plan benefits, that are addressed in greater detail below.

Mandatory Services	Optional Services
<ul style="list-style-type: none"> • In/outpatient hospital • Physician, midwife, and nurse practitioner • Nursing home • Home health • Screening and treatment (EPSDT) for kids under 21 • Family Planning • Rural health clinics, federally qualified health centers 	<ul style="list-style-type: none"> • Personal care • ICF-IID • Prescription drugs • Therapies-OT/PT/Speech • Eyeglasses • Dental services • Targeted case management • Mental Health Services • HCBS State plan services <ul style="list-style-type: none"> ◦ 1915(i) State plan HCBS ◦ 1915(k) Community First Choice ◦ 1915(j) Self-directed Personal care ◦ 1915(b)(4) Selective contracting

Q. What if a service isn't immediately available or will take some planning time to deliver?

A. Section 1902(a)(8) of the Social Security Act requires that states, "... provide that all individuals wishing to make application for medical assistance under the [state] plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals..." Although this regulation references making application, a considerable body of case law has established that this requirement also applies to service delivery.⁴ In other words, states have an obligation to make sure that state plan services are available to individuals. In fact, CMS has published a regulation that holds states accountable for making sure there is sufficient access to state plan services.

Q. What is the timeframe for "reasonable promptness"?

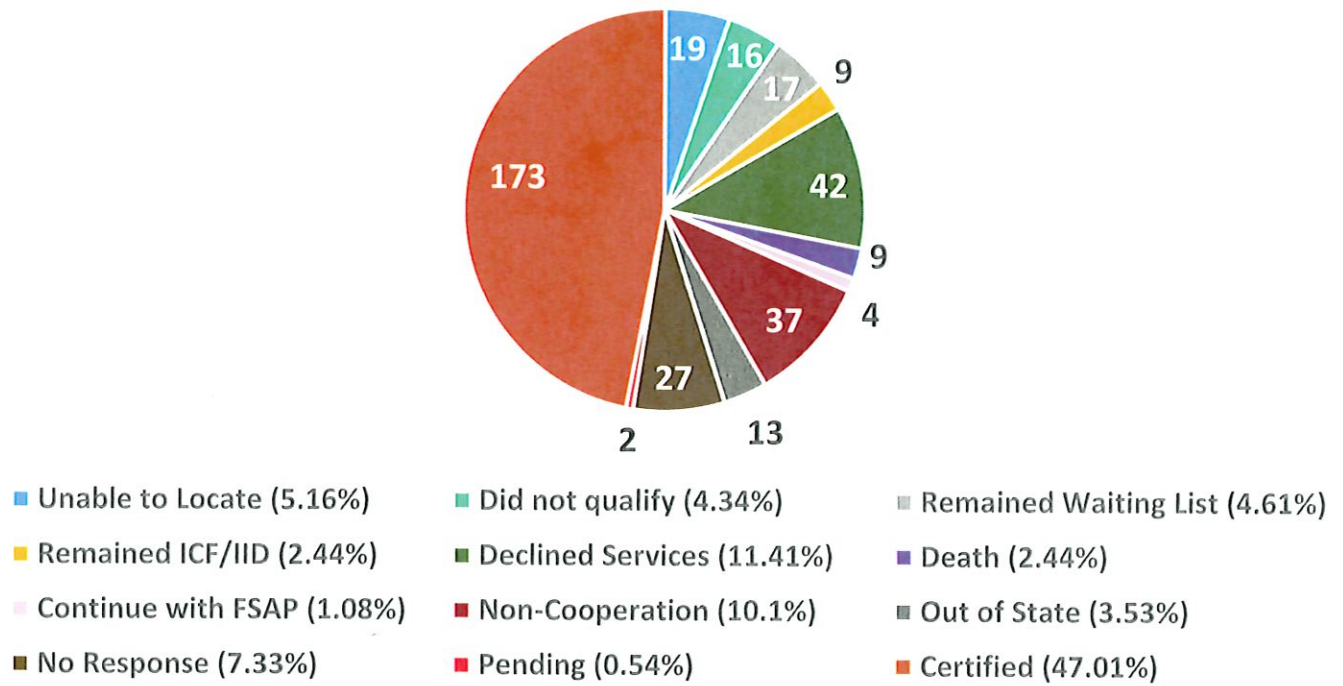
A. Under 42 CFR § 435.911(a) the Department of Health and Human Services (HHS) addresses the statutory reasonable promptness provision setting specific time limits to determine eligibility: 90 days for applicants who apply based on disability and 45 days for all others. While this citation again is tied to eligibility determinations, it has been broadly interpreted in multiple cases to also apply to service delivery.⁵ Thus, CMS has indicated expectations using this 45-90 day timeframe with regard to services initiation.

³ See www.medicaid.gov/medicaid/benefits/epsdt/index.html.

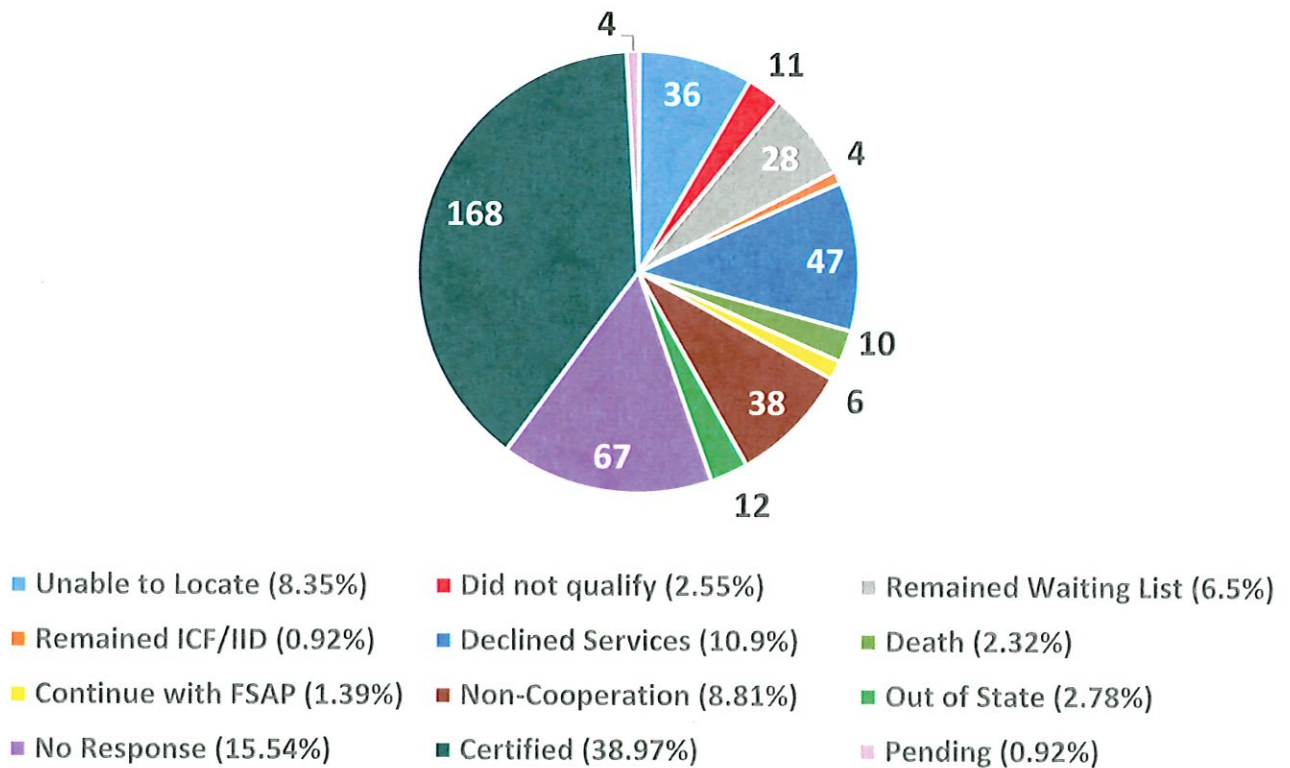
⁴ See lawcrawler.findlaw.com/LCsearch.html?restrict=lp&client=lp&entry=medicaid+reasonable+promptness.

⁵ Ibid.

Worked Waiting List Cases Fiscal Year 2020 (368 Total)



Worked Waiting List Cases Fiscal Year 2021 (431 Total)





CHAPTER I

The Opportunity to Transform LTSS



How States Organize the Delivery of LTSS Matters

States organize the administration and delivery of LTSS in a variety of ways. It is important for Medicaid leaders to understand how their system is organized because this impacts the levers Medicaid leaders can use to transform and strengthen it. It is also important to note that the terminology used to describe components of the LTSS system can vary significantly across states and within a state's LTSS system.

Partnership with sister state agencies. In FY2016, services for individuals with intellectual and developmental disabilities (ID/DD) were operated or co-operated by agencies other than the single state Medicaid agency in 30 states, physical disability services were operated by another agency in 16 states, and LTSS for older adults were operated by another state agency or department in 20 states.⁹

Service delivery model. Twenty-five states deliver some portion of LTSS to individuals covered by Medicaid through a capitated managed care model.¹⁰ Other states deliver LTSS through a fee-for-service delivery model where the state contracts with the home-and community-based provider agencies, nursing facilities, and other community support providers directly.

While person-centeredness is the driving goal of all LTSS, this principle often comes into tension with the realities of the administration of public programs and the need for clear and reliable policies and program structures and systems, which can lead to programs being overly rigid and inflexible. This challenges state Medicaid leaders and federal policymakers to constantly strive to balance the need for reliable program structures and systems with the goal of making sure they are flexible enough to meet individual needs. One approach states use to navigate this challenge is to center the person in the system and organize the program structures around the principles of access, choice, person-centered care, person/family-professional partnership, care/service coordination, person-specific outcome metrics, and quality improvement.

In summer 2021, NAMD convened an Executive Working Group of state Medicaid LTSS experts and national thought leaders to identify a framework of options that states could use to respond to this opportunity to improve and strengthen these services. This framework explores how states can meet the LTSS needs of individuals so they can maximize their health and thrive in the community of their choosing. It was designed with the current realities in mind – particularly the opportunity Medicaid programs have with the American Rescue Plan Act funding which could plant the seeds for long-term, sustained improvements.

⁹ [State Medicaid Operations Survey: 5th Annual Survey of Medicaid Directors](#). National Association of Medicaid Directors. December 2016.

¹⁰ [Managed Long-term Services and Supports](#). Medicaid and CHIP Payment and Access Commission.

From: [Galloway, Samantha](#)
To: [Shannon Rios](#)
Cc: [Frank Magness](#); [Ryan Maren](#)
Subject: RE: Project update and follow-up questions
Date: Wednesday, March 31, 2021 8:37:00 AM
Attachments: [image002.png](#)

Shannon,

Thank you for your follow up. We haven't awarded either contract but both are very close. Because of procurement rules I can't share details. The \$2 mil request would be used to maintain the current momentum on the chronological list. There must have been a misunderstanding regarding the \$5 mil estimate to eliminate the WL. That isn't a number I have ever forecasted and I don't believe that is anywhere in range.

Regarding the research, I was of the impression from Mike that you were only asking us to provide existing or easily gathered data points. What you are requesting is well beyond that and would require a significant redirection of resources.

Samantha

From: Shannon Rios <shannon.rios@okloft.gov>
Sent: Monday, March 15, 2021 8:56 AM
To: Galloway, Samantha <Samantha.Galloway@okdhs.org>
Cc: Frank Magness <frank.magness@okloft.gov>; Ryan Maren <ryan.maren@okloft.gov>
Subject: [EXTERNAL] Project update and follow-up questions

Samantha – Thank you for your patience with us over the past few months as we get all of our projects up and running. We have had several legislative deadlines that have necessitated new deadlines on a variety of things. Happy to report that we are now able to focus more time and attention to the Waiting List project. We have a few follow-up questions for you and your team at this time. We would appreciate a deadline of April 9th for this information. If there is any reason that time frame does not work for your team, please let us know. Please also let me know if you have any questions of us.

Please provide an update on these project/contract efforts. Do you have Statements of Work or Work Plans that you can share with us? Has a needs assessment been chosen? If so, please share. What vendors have been chosen and what are the applicable milestones/deadlines? What is the funding source for these contracts?

- 1) DDS is seeking a single case management software system to be used by OKDHS/DDS case managers, other state employee staff and contract providers. The system must be able to manage a wide array of supports, including direct support services to HCBS recipients and those on the waiting list and related tasks.
- 2) DDS is seeking a third party to use a standardized assessment tool and case management system selected by DDS to assess everyone currently on the HCBS Waiver waiting list and all future applicants. The vendor must provide robust navigation services

for people waiting to meet their needs by connecting them to existing community resources in their local area and beyond, other federal and state entitlement programs, and being the point of contact when they believe their needs have changed, including helping them request emergency services.

We understand that you have again been assured approximately \$2 million in dedicated funds to serve the waiting list. Do you anticipate that the way that money will be used is the same as in SFY 2021? Or, with the introduction of these new contracts, do you expect to spend that money differently in SFY 2022?

DHS mentioned in the Entrance Conference that you have no traditionally performed "intake" work with those signing up for the waiting list due to the nature of the fact that with Medicaid, when that work is conducted it begins a clock for expected service delivery. LOFT learned that Missouri does perform intake and case management work with those who are waiting from the very beginning. Please help us understand this difference. How is it that some states are able to conduct intake work with those who are waiting without having the timer begin for services?

In terms of comparative analysis, what services does Oklahoma provide on waivers compared to other states in our region? What do we spend per person for IDD services compared to other states in our region?

DHS mentioned in the Entrance Conference that you estimate you could serve everyone on the waiting list for approximately \$5 million additional dollars annually. How did you develop that estimate? Please provide any analysis you have estimating what it would cost to serve those on the waiting list.

Thank you,



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